

3
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18311

1. DECEASED-NAME (Type or print)			First <i>Robert</i>	Middle <i>HENRY</i>	Last <i>Cooper</i>	2a. DATE OF DEATH Month <i>12</i>	Day <i>22</i>	Year <i>68</i>	2b. HOUR <i>3:30 P.M.</i>	
3. SEX <i>MALE</i>	4. RACE <i>WHITE</i>	S. DATE OF BIRTH <i>8/21/1909</i>	6. AGE (In years lost birthday) <i>59</i> YRS.			IF UNDER 1 YEAR MONTHS <i>5</i>		IF UNDER 24 HRS. DAYS <i>18</i>		
7a. BIRTHPLACE (State or foreign country) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>US</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>TALBOT</i>							
10. CITY OR TOWN OF DEATH <i>EASTON</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Lumber</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>	13b. COUNTY <i>TALBOT</i>	13c. CITY OR TOWN <i>TILGHMAN</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER						
14. FATHER'S NAME First <i>THOMAS H. COOPER</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>VIRGINIA L. ROE</i>	Middle <i></i>	Last <i></i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>213-01-3301</i>	17. INFORMANT <i>Mrs. ROBERT COOPER, TILGHMAN, MD</i>	Address <i>110 Main Street, Tilghman, MD</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>days</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>470 X</i>						DUE TO, OR AS A CONSEQUENCE OF <i>Chronic bronchitis, emphysema</i>				
Conditions, if any, which gave rise to immediate cause (o), stating the <u>underlying cause</u> lost.						DUE TO, OR AS A CONSEQUENCE OF <i>Obstruction - Type II chronic bronchitis</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>481 X</i>										
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Blow</i>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>Office</i>		21f. LOCATION Street or R.F.D. No. <i>100</i>	City or Town <i>Tilghman</i>		County <i>Talbot</i>	State <i>MD</i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>10/22/68</i> , to <i>12/24/68</i> , that (I) (we) last saw the deceased alive on <i>10/22/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <i>R. Lane Wroth</i>		22c. DATE SIGNED <i>12-24-68</i>	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (Type) <i>R. LANE WROTH</i>		M.D.	22e. ADDRESS <i>St. Michaels, Maryland 21663</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>12/24/1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>METHODOIST</i>			23d. LOCATION (City or Town) <i>TILGHMAN, MD</i>		(County) <i></i>	(State) <i></i>	
24. FUNERAL DIRECTOR <i>Maria E. Neumann & Son</i>		ADDRESS <i>EASTON, MD.</i>	25a. REC'D BY REGISTRAR <i>DEC 27 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
VR A15 (4) 30M REV. 1/68										

1168

DEC 3 1968

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

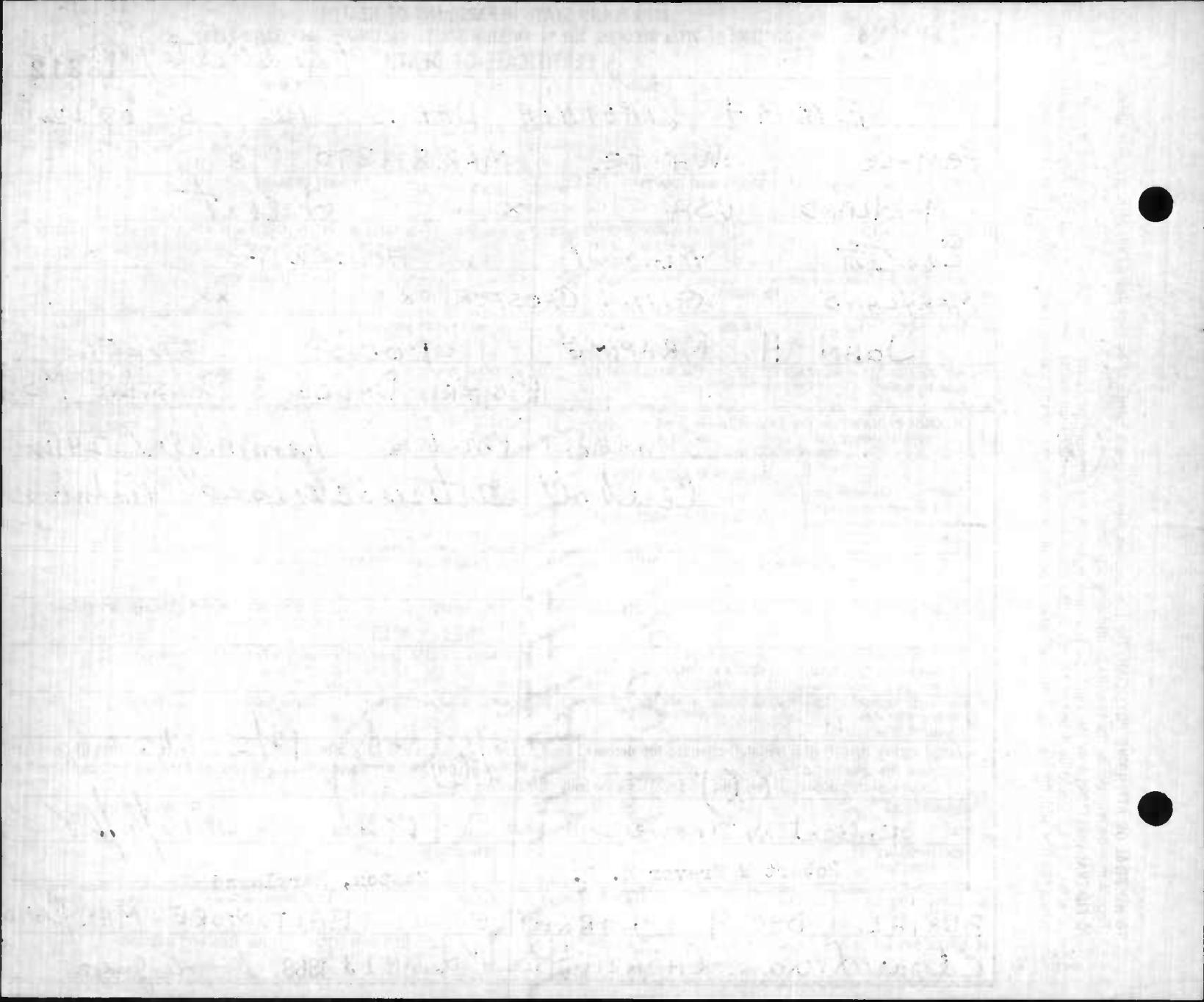
18298

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201

CERTIFICATE OF DEATH

(Duplicate) *Lost*
18298

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 2b. HOUR
EMMA VIRGINIA DADDS				12 5 68			610 P.M.
3. SEX	4. RACE	S. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
FEMALE	WHITE	MAR. 8-1890			78	YRS.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Balbut		
MARYLAND	USA						
10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HODSEN, FC			12b. KIND OF BUSINESS OR INDUSTRY XX		
MARYLAND	Q.A.	13c. CITY OR TOWN CHESTER	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER XX			
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
JOHN H. KRAMME				Louise ENGEL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT RICHARD DADDS - STEVENSVILLE, Md.	Address	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
431.9		Massive Cerebral Hemorrhage 2-24 hrs					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis		Unknown			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 12/5/68, to 12/5/68, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert W. Trever	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 12/6/68			
22d. PHYSICIAN'S NAME (Type) Robert W. Trever M.D.	22e. ADDRESS Easton, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE Dec. 9	23c. NAME OF CEMETERY OR CREMATORIAL LORRAINE	23d. LOCATION (City or Town) BALTIMORE	(County) MARYLAND	(State)		
24. FUNERAL DIRECTOR Edgar L. Lane - CHURCH Hill MD	ADDRESS DAIAN 13 1969	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge				
VR A16 30M REV 1/68							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon papers, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

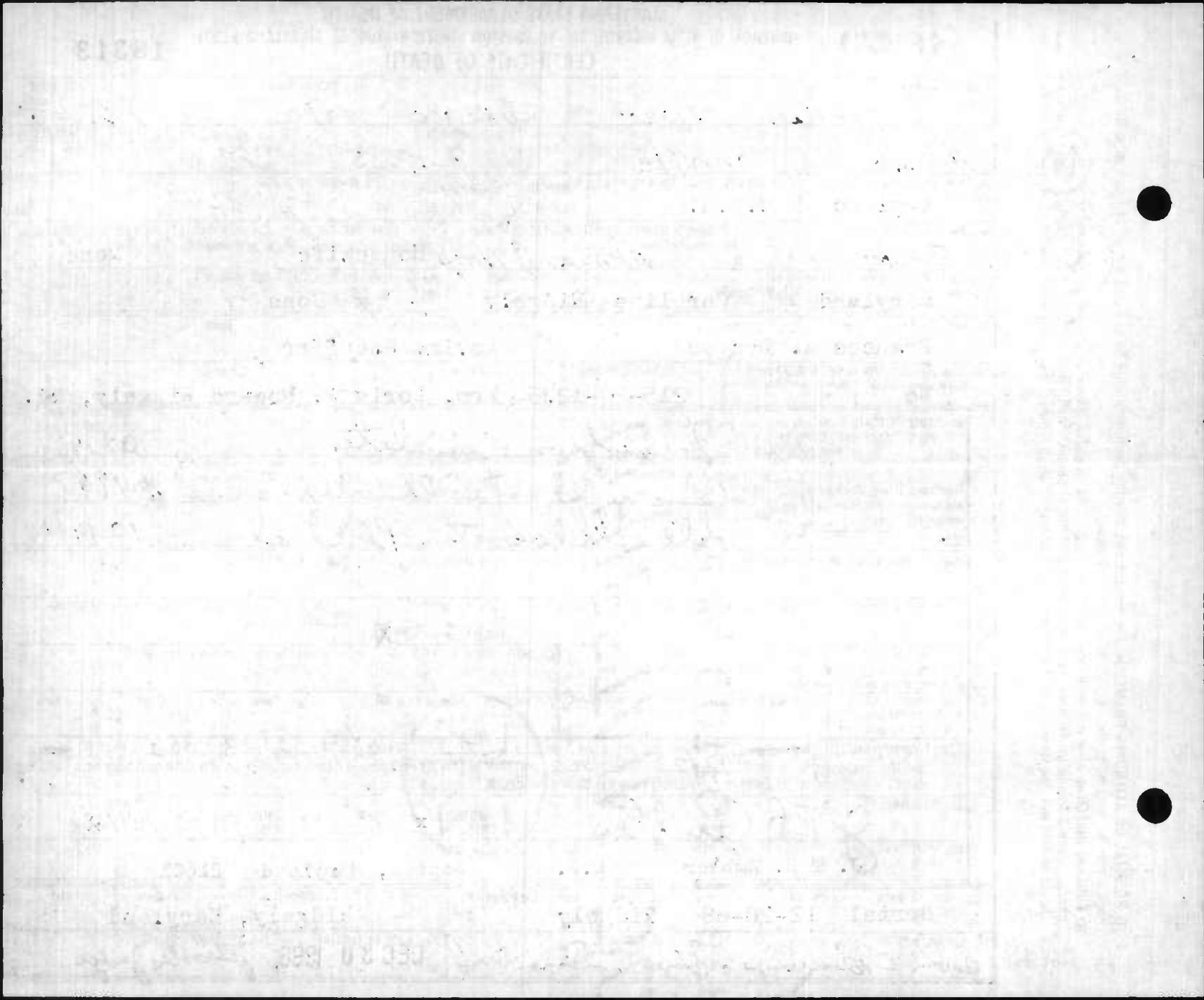
18300

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18313

1. DECEASED-NAME (Type or print)	First <i>Nellie Mae</i>	Middle <i>Dragoo</i>	Last <i>Dragoo</i>	2a. DATE OF DEATH Month <i>Dec 23</i>	Day <i>Year</i>	2b. HOUR <i>640 PM</i>
3. SEX <i>Female</i>	4. RACE <i>white</i>	S. DATE OF BIRTH <i>7-17-85</i>	6. AGE (In years last birthday) <i>83 yrs.</i>	IF UNDER 1 YEAR MONTHS <i>0</i>		IF UNDER 4 HRS. DAYS <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Talbot</i>	Md.		
10. CITY OR TOWN OF DEATH <i>Easton</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hosp.</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Caroline</i>	13c. CITY OR TOWN <i>Ridgely</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>None</i>		
14. FATHER'S NAME First <i>Frances A.</i>	Middle <i>Dragoo</i>	15. MOTHER'S MAIDEN NAME First Middle <i>Levina Stauffer</i>	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>215-20-1276</i>	17. INFORMANT <i>Mrs. Doris A. Howard Ridgely, Md.</i>	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>174X</i>	DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cancer of breast with metastases</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10/1968</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(c) <i>Fall with lacerations of forehead</i>			<i>Jan 1967</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>170X</i>						
19a. DATE OF OPERATION MEDICAL CERTIFICATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <i>12/11/60</i> , to <i>12/23/68</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>12/23/68</i> , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death.						
22b. SIGNATURE <i>J. T. B. Ambler</i>	DEGREE <input checked="" type="checkbox"/> MED. PHYS. <input type="checkbox"/> STAFF DIRECTOR <input type="checkbox"/> PHYS.	22c. DATE SIGNED <i>12/24/68</i>				
22d. PHYSICIAN'S NAME (Type) <i>J. T. B. Ambler</i>	M.D.	22e. ADDRESS <i>Easton, Maryland 21601</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>12-28-68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ridgely</i>	23d. LOCATION (City or Town) <i>Ridgely, Maryland</i>	(County) <i>Caroline</i>	(State) <i>Maryland</i>	
24. FUNERAL DIRECTOR <i>John E. Bourne Greentree Md</i>	ADDRESS <i>John E. Bourne Greentree Md</i>	25a. REC'D. BY REGISTRAR DATE <i>DEC 30 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



Item6 FilmG407 12/16/68 kk MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18391

18314

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, sign and 2nd director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, sign and 2nd director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>JENNIE W.</i>	Middle <i>DYES</i>	Last <i>DYES</i>	2a. DATE OF DEATH Month <i>12</i>	Day <i>7</i>	Year <i>68</i>	2b. HOUR <i>10:15</i>					
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>April 13, 1897</i>			6. AGE (In years last birthday) <i>70 1/2</i>	YRS.	IF UNDER 1 YEAR MONTHS <i>0</i>	IF OVER 24 HRS. DAYS <i>0</i>	HOURS <i>0</i>	MIN. <i>0</i>		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Talbot</i>									
10. CITY OR TOWN OF DEATH <i>EASTON</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MEMORIAL</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Pickle factory</i>			12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13c. CITY OR TOWN <i>Dorchester Cambridge</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>Trailer Court Rd.</i>									
14. FATHER'S NAME First <i>Martin Wheatley</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Rittia Short</i>	Middle <i></i>	Last <i></i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>213-24-4250</i>	17. INFORMANT <i>J. Elmer Dyes</i>	Address <i>Hurlock, Md.</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Uncertain</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple myeloma</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) _____ stating the underlying cause _____ last. (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>203 X</i>												
19a. DATE OF OPERATION <i>203 X</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>At home, Farm, Street, Factory.</i>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. <i></i>	City or Town <i></i>	County <i></i>	State <i></i>				
22a. I certify that (I) (this hospital) attended the deceased from <i>12-5</i> , 19 <i>68</i> , to <i>12-7</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12-7</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Robert W. Trever</i>		M.D. DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>12-8-68</i>						
22d. PHYSICIAN'S NAME (Type) <i>Robert W. Trever</i>		M.D.			22e. ADDRESS <i>Easton, Maryland 21601</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12/10/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>East New Market Cem.</i>		23d. LOCATION (City or Town) <i>East New Market, Md.</i>		(County) <i></i>		(State) <i></i>		
24. FUNERAL DIRECTOR <i>Harvey Bellamy - J. Federaburg, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>DEC 12 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

208 313

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11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please return carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First HENRY H	Middle FARQUHAR	Last	2a. DATE OF DEATH Month 12 Day 15 Year 68	2b. HOUR 6:30 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 7/13/1884	6. AGE (In years at birthday) 84 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0
7a. BIRTHPLACE (State or foreign country) Md	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Talbot	Md.	
10. CITY OR TOWN OF DEATH EASTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) INDUSTRIAL MANAGEMENT	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY TALBOT WITTMAN	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First ROGER B. FARQUHAR	Middle 	Last 	15. MOTHER'S MAIDEN NAME First CAROLINE MILLER	Middle 	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 242-76-5887	17. INFORMANT ANNE F. HAMER, FREDERICKSBURG, VA	Address APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure DUE TO, OR AS A CONSEQUENCE OF Severe inferior M.I. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 4201 DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic coronary DUE TO, OR AS A CONSEQUENCE OF (c) artery					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 19 Nov 68 to 15 Dec 68 , that (I) (we) last saw the deceased alive on 2-14 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jay M. Reeser MD		22c. DEGREE ATTENDING PHYS. MD.	22d. MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	DATE SIGNED 12-15-68
22e. PHYSICIAN'S NAME (Type) Jay M. Reeser Jr. MD		22e. ADDRESS Michaeli MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE 12/17/1968	23c. NAME OF CEMETERY OR CREMATORIAL FORT LINCOLN	23d. LOCATION (City or Town) WASHINGTON, D.C.	(County) 	(State)
24. FUNERAL DIRECTOR Maurice L. Neumann Son EASTON, Md.	ADDRESS 	25a. REC'D BY REGISTRAR DEC 17 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

225

500



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

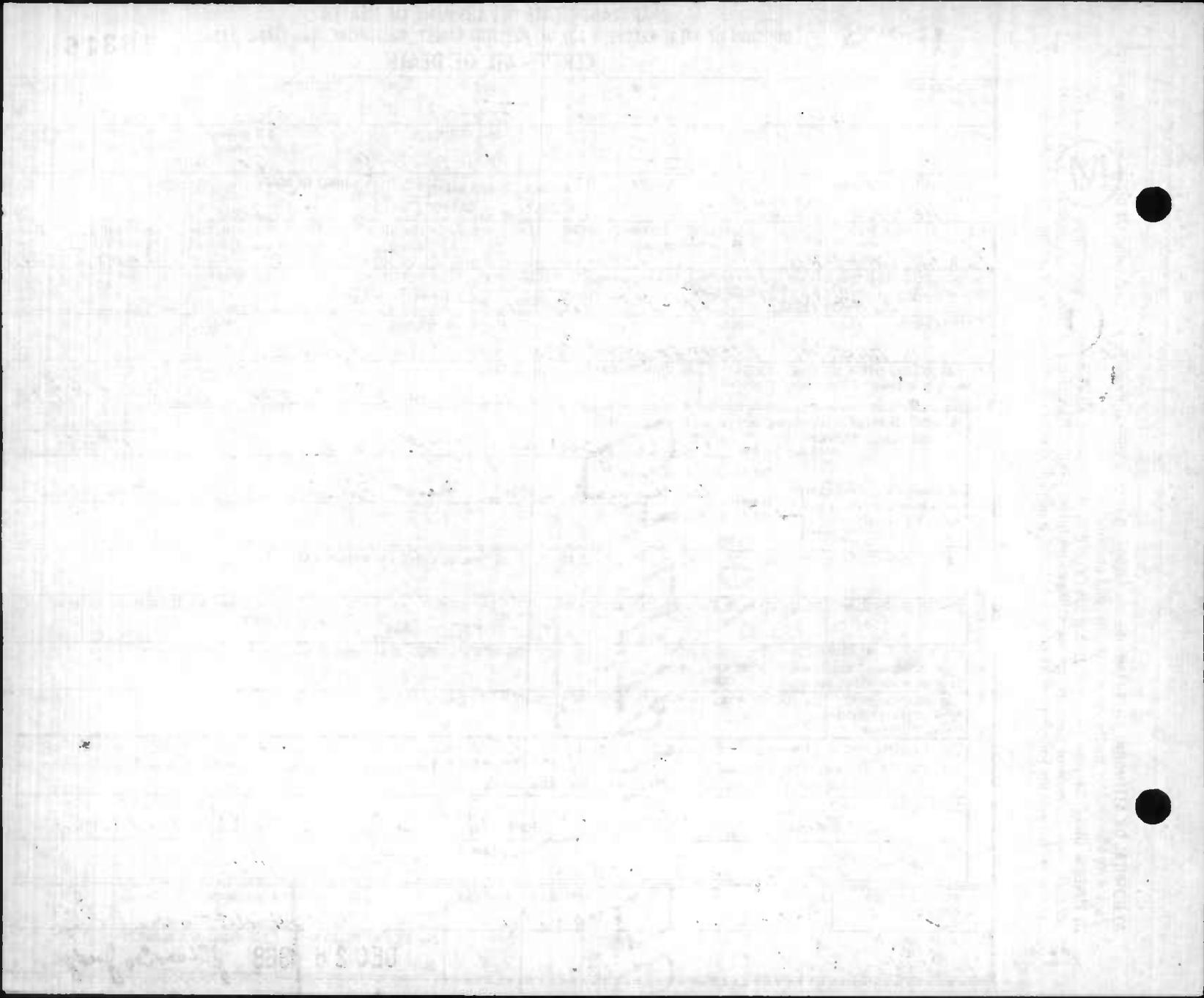
18393

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18316

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First <i>THOMAS</i>	Middle <i>Thomson</i>	Last <i>FIRTH</i>	2a. DATE OF DEATH Month <i>DEC</i>	Doy <i>22</i>	Year <i>1968</i>	2b. HOUR <i>M</i>
3. SEX <i>MALE</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH <i>Nov 1, 1878</i>	6. AGE (In years last birthday) <i>90</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	HOURS <i>00</i>	MIN. <i>00</i>
7b. BIRTHPLACE (State or foreign country) <i>PENNA</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>TALBOT</i>	Md.			
10. CITY OR TOWN OF DEATH <i>RURAL TRAPPE</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>RETIRED</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>REAL ESTATE</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>	13b. COUNTY <i>TALBOT</i>	13c. CITY OR TOWN <i>TRAPPE</i>	13d. INSIDE CITY LIMITS? <i>YES</i>	13e. STREET AND NUMBER <i>Mrs Thomas Firth TRAPPE MD</i>			
14. FATHER'S NAME First <i>AUSTIN</i>	Middle <i>MONTGOMERY</i>	Last <i>Firth</i>	15. MOTHER'S MAIDEN NAME First <i>SARAH LIVZEY</i>	Middle <i></i>	Last <i></i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>Mrs Thomas Firth</i>	Address <i>TRAPPE MD</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>arteriosclerotic heart disease</i>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <i>4200</i>							
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)							
21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19							
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)							
21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>8 Dec</i> , 1968, to <i>22 Dec</i> , 1968, that (I) (we) last saw the deceased alive on <i>21 Dec</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Stephen P. Carney</i>							
22c. DATE SIGNED <i>12-22-68</i>							
22d. PHYSICIAN'S NAME (Type) <i>STEPHEN P. CARNEY</i>							
22e. ADDRESS <i>Easton, Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Dec 22 68</i>							
23b. DATE <i>Dec 22 68</i>							
23c. NAME OF CEMETERY OR CREMATORIAL <i>CEDAR HILL</i>							
23d. LOCATION (City or Town) (County) (State) <i>WASHINGTON DC</i>							
24. FUNERAL DIRECTOR ADDRESS <i>Nellie Carl Cockton Ind</i>							
25a. RECD BY REGISTRAR DATE <i>DEC 26 1968</i>							
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



3
1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18317

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 655 P.M.
ALICE	A.	GRATTAN		12 28 68	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.
Female	WHITE	8-28-01			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
NEW YORK	USA		TALBOT		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
EASTON	MEMORIAL Hosp.	HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
MARYLAND	TALBOT ST. MICHIGAN		TALBOT ST.		
14. FATHER'S NAME	First	Middle	Last	I.S. MOTHER'S MAIDEN NAME	First
JOHN BEARDSLEY ALDEN				ELIZABETH SEGUINE	Middle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address		
No	263-60-7904	Mrs. Jane A. Irwin, Hammonton, N.J.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 471X	4 days -				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 480X					
(b) Flu					
DUE TO, OR AS A CONSEQUENCE OF (c)					
Part 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
Emphysema - severe, cor pulmonale,					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 12-28-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	1960, 19, to 12-28, 1968				
22b. SIGNATURE Guy M. Reeser, M.D.	22c. DATE SIGNED 12-30-68				
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS 17 Michael Rd				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Jan 2, 1969	23c. NAME OF CEMETERY OR CREMATORIAL Moravian Cemetery	23d. LOCATION (City or Town) Newark, Staten Island, N.Y.	(County)	(State)
24. FUNERAL DIRECTOR	ADDRESS Harrison Edmund, St Michaels, Ind.	25a. REC'D BY REGISTRAR JAN 3 1969	25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (4) 30M REV. 1/68					

Department 202 All

MARYLAND STATE DEPARTMENT OF HEALTH

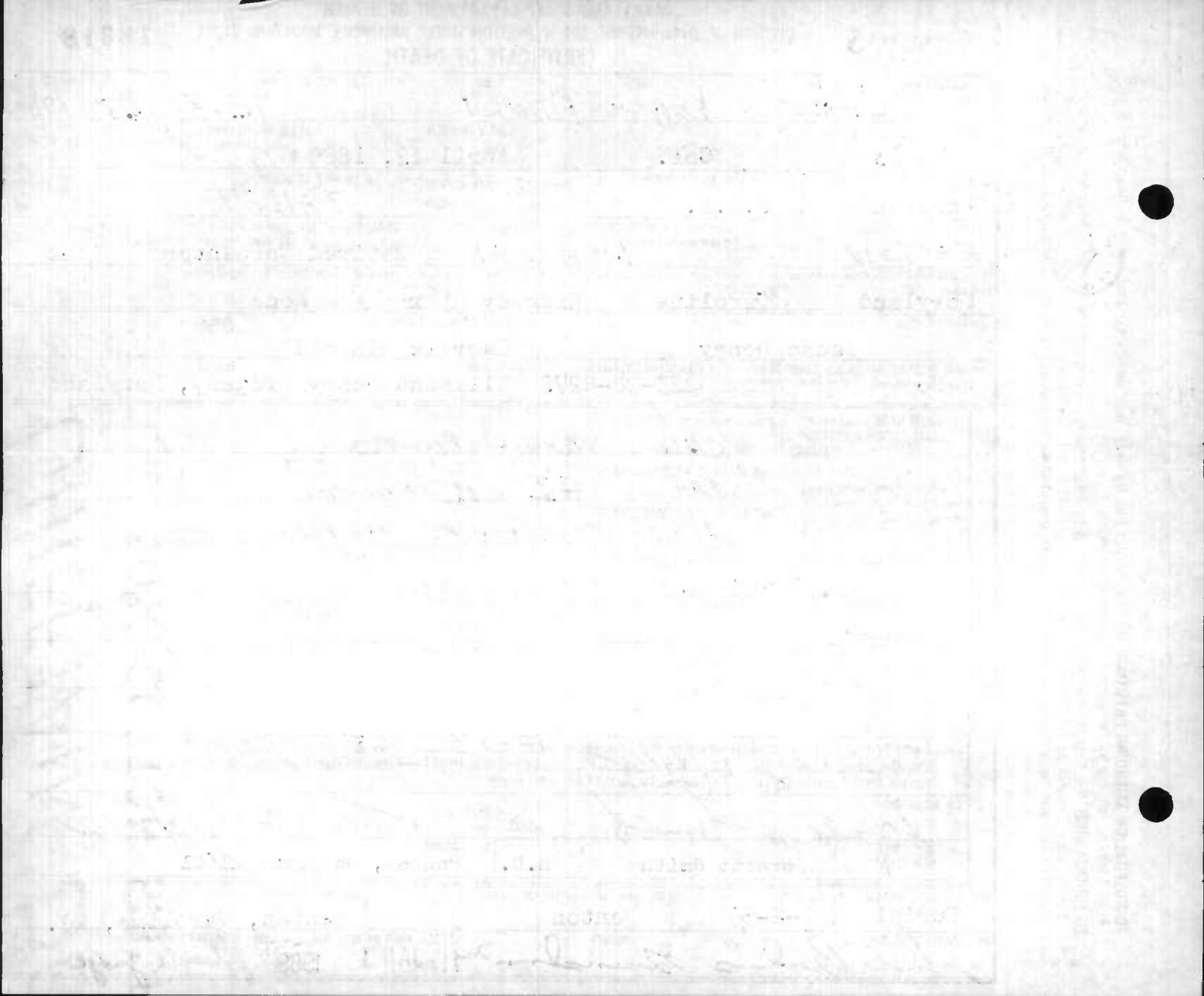
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18318

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First JAMES	Middle ISAAC	Last HENRY	2a. DATE OF DEATH Month 12	Day 30	Year 1968	2b. HOUR 12 PM
3. SEX Male	4. RACE Col.	5. DATE OF BIRTH April 12, 1889			6. AGE (In years last birthday) 79	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	9. COUNTY OF DEATH TALBOT				
10. CITY OR TOWN OF DEATH EASTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Carpenter	12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Caroline	13c. CITY OR TOWN Ridgely	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER None			
14. FATHER'S NAME First Isaac Henry	Middle	Last	15. MOTHER'S MAIDEN NAME First Georgia Ringold	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (Unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 223-28-8278	17. INFORMANT Willmina Henry Ridgely, Maryland	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC RENAL FAILURE 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC G.I. DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE HYPOCKIUMIC INFECTION							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 GRANULARIS ADRENAL SCURVOSIT							
19a. MEDICAL CERTIFICATION None	19b. DATE OF OPERATION None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 12-13 , 19 68 , to 12-30-68 , 19 69 , that (I) (we) last saw the deceased alive on 12-29-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dorsett Smith	DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 12/30/68			
22d. PHYSICIAN'S NAME (Type) Dorsett Smith	22e. ADDRESS Easton, Maryland 21601						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-2-69	23c. NAME OF CEMETERY OR CREMATORIAL Denton	23d. LOCATION (City or Town) Denton, Caroline, Md.	(County)	(State)		
24. FUNERAL DIRECTOR John E. Bowles	ADDRESS Greensboro, N.Y.	25a. REC'D BY REGISTRAR DATE JAN 2 1969	25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

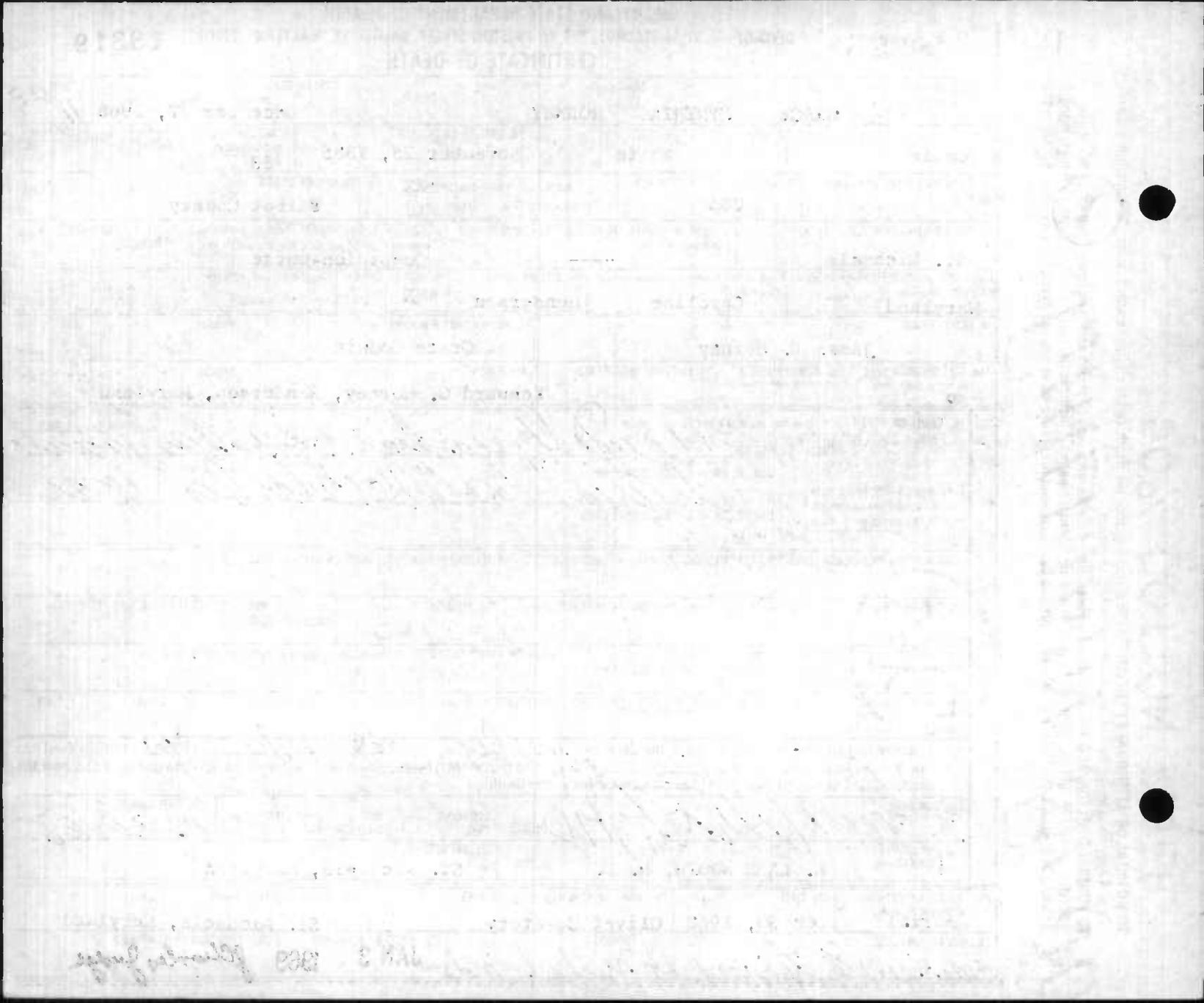
CERTIFICATE OF DEATH

18319

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18396			2. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR 11:30 P.M.
			GRACE CYNTHIA HORNEY						December 27, 1968		
3. SEX		4. RACE		S. DATE OF BIRTH		6. AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female		White		November 25, 1885		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		9. COUNTY OF DEATH		Md.					
USA		USA		Balbot County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Companion-nurse			12b. KIND OF BUSINESS OR INDUSTRY		
St. Michaels											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
			Caroline		Henderson						
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
			James D. Horney			Grace Godwin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO.			17. INFORMANT		Address			
						Kennard G. Horney, Henderson, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) 4109 DUE TO, OR AS A CONSEQUENCE OF (c) 4109 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from 21 Dec, 1968, to 27 Dec, 1968, that (I) (we) last saw the deceased alive on 21 Dec, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. Lane Wroth, M.D.											
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			22c. DATE SIGNED 12-30-68					
R. Lane Wroth, M. D.			St. Michaels, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town)		(County)	(State)		
Burial		Dec 30, 1968		Olivet Cemetery		St. Michaels, Maryland					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Harrison E. Leonard, St. Michaels Md.				JAN 3 1969		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1839?

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18320

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First <i>John</i>	Middle	Lost <i>Horst</i>	2d. DATE OF DEATH Month <i>Dec.</i> Day <i>21</i> Year <i>1968</i>	2b. HOUR <i>6:35 P.M.</i>
3. SEX <i>Male</i>	4. RACE <i>white</i>	S. DATE OF BIRTH <i>10-5-03</i>	6. AGE (In years lost birthday) YRS. <i>65</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Talbot</i>	Md.	
10. CITY OR TOWN OF DEATH <i>EASTON</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hosp</i>	12. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>CARPENTER</i>	13b. COUNTY <i>TALBOT EASTON</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>	13c. CITY OR TOWN <i>TALBOT EASTON</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>RD 2</i>		
14. FATHER'S NAME First <i>JASPER HORST</i>	Middle	Lost	15. MOTHER'S MAIDEN NAME First <i>HENRIETTA HOLLAND</i>	Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown	16b. SOCIAL SECURITY NO. <i>218-05-8395</i>	17. INFORMANT <i>MRS. JOHN HORST, EASTON, MD</i>	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>acute pulmonary edema</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>calcific arter stenosis</i>			5 years		
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>4211</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (the hospital) attended the deceased from <i>November, 1965</i> , to <i>21 Dec., 1968</i> , that (I) (we) last saw the deceased alive on <i>21 Dec., 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Stephen S. Clegg</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>12-21-68</i>	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL 1324/1968</i>	23b. DATE <i>1324/1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>WOODLAWN MEMORIAL PARK EASTON, MD</i>	23d. LOCATION (City or Town) <i>PARK EASTON, MD</i>	(County)	(State)
24. FUNERAL DIRECTOR <i>Harriet Wilkinson, Easton, Md.</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE <i>DEC 27 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

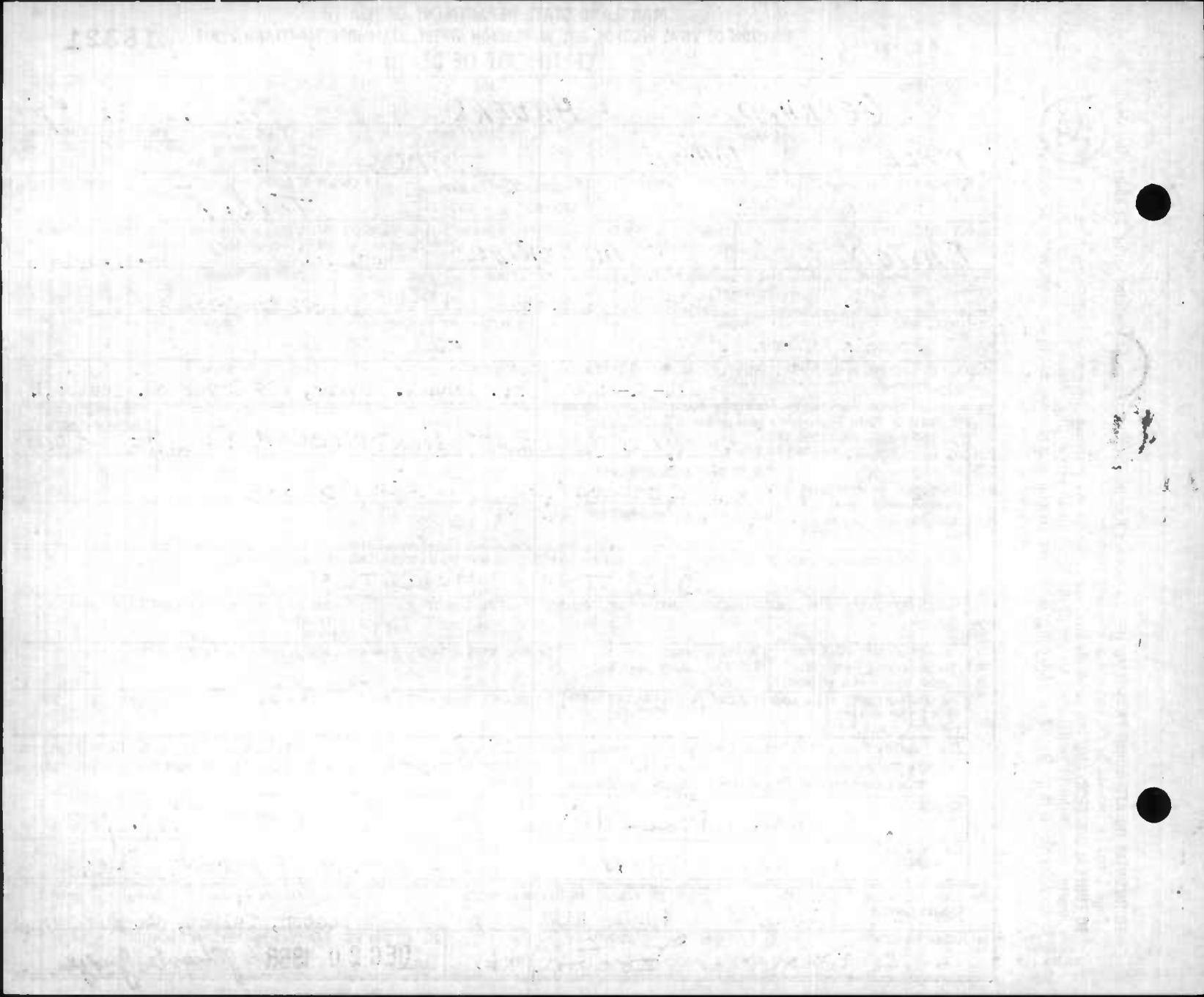
18321

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First GERRARD	Middle	Last HUVERS	2a. DATE OF DEATH Month 12	Doy 15	Year 68	2b. HOUR 46⁰	
3. SEX MALE	4. RACE WHITE	S. OATE OF BIRTH 12/25/1885	6. AGE (In years last birthday) 82			IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. DAYS 0		
7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Talbot			Md.					
10. CITY OR TOWN OF DEATH EASTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) machinist			12b. KIND OF BUSINESS OR INDUSTRY selfemployed			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Talbot	13c. CITY OR TOWN Easton	13d. INSIDE CITY LIMITS? YES		13e. STREET AND NUMBER 622 Dover Road					
14. FATHER'S NAME First Francis Huvers	Middle	Last	15. MOTHER'S MAIDEN NAME First unk			Middle	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes	16b. SOCIAL SECURITY NO. 214-32-2406	17. INFORMANT Mrs. Lena L. Huvers, 622 Dover Rd. Easton, Md.			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LEFT VENTRICULAR FAILURE 12 hours										
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY THROMBOSIS										
DUE TO, OR AS A CONSEQUENCE OF (c)										
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY THROMBOSIS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 DIABETES MELLITUS										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.			City or Town	County	State			
22a. I certify that (I) (this hospital) attended the deceased from 1967 , 19, to 12/15 , 19, 68, that (I) (we) last saw the deceased alive on 12/15/68 , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE C. R.W. Bain MD	ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 12/16/68								
22d. PHYSICIAN'S NAME (Type) C. R.W. Bain	22e. ADDRESS 210 DOVER, EASTON, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/19/68	23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill			23d. LOCATION (City or Town) Easton, Talbot, Maryland		(County)	(State)		
24. FUNERAL DIRECTOR Jay D. Huvers	ADDRESS Easton, Md.			25a. REC'D BY REGISTRAR DEC 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon copy pages 1 and 2 to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

18329

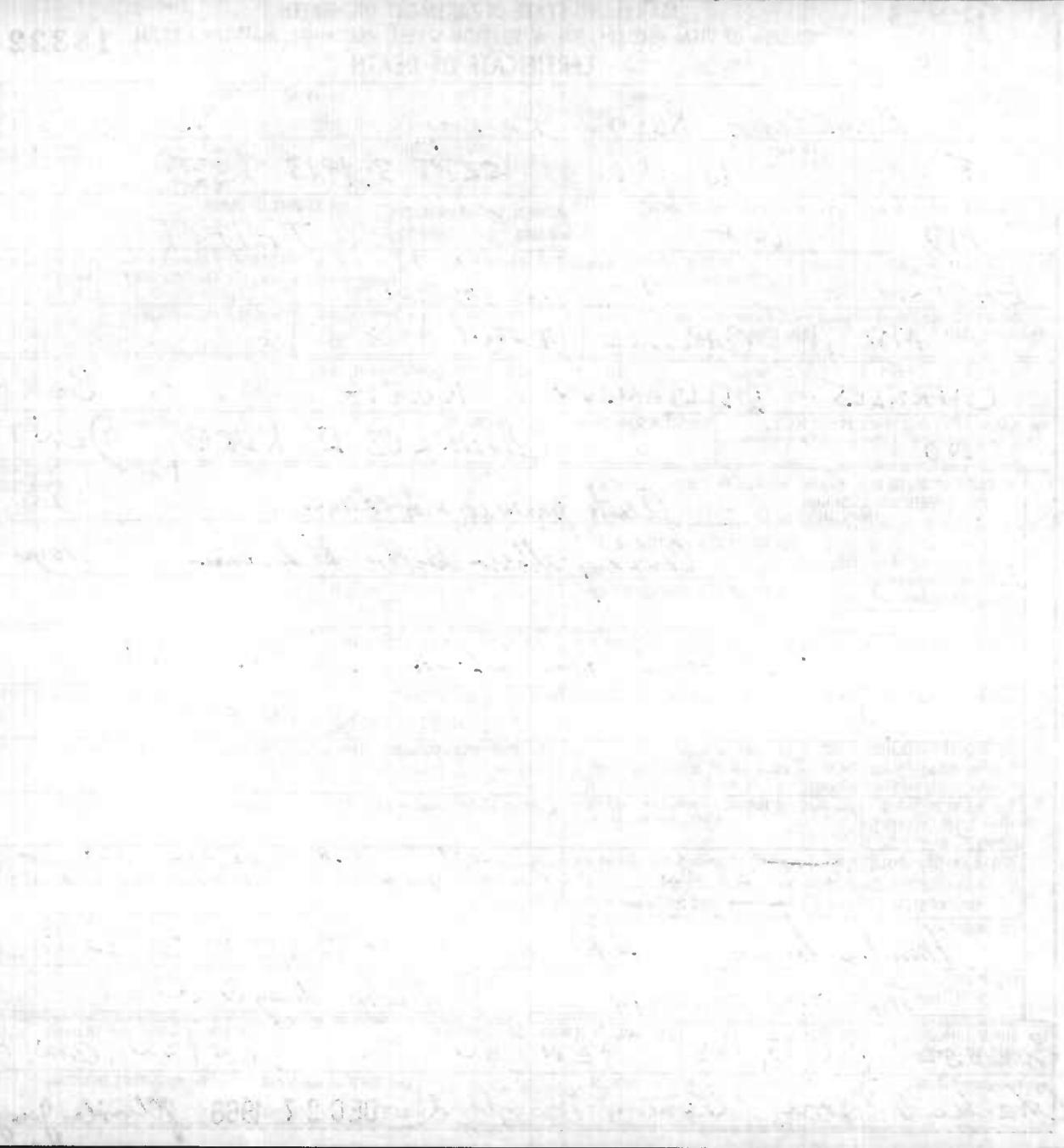
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18322

Item 3 Film G408 1/15/69 kk

1. DECEASED-NAME (Type or print)	First <i>Geraldine</i>	Middle <i>Ruth</i>	Lost <i>Kirby</i>	2d. DATE OF DEATH Month <i>12</i>	Doy <i>22</i>	Year <i>1968</i>	2b. HOUR <i>3A M</i>
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>SEPT 3, 1913</i>		6. AGE (In years last birthday) <i>55</i>	IF UNDER 1 YEAR MONTHS <i>YRS.</i>	IF UNDER 24 HRS. MONTHS <i>DAYS</i>	IF UNDER 24 HRS. HOURS <i>MIN.</i>
7a. BIRTHPLACE (State or foreign country) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT</i>			
10. CITY OR TOWN OF DEATH <i>EASTON</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Memorial Hospital</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>	13b. COUNTY <i>CAROLINE</i>	13c. CITY OR TOWN <i>DENTON</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>121 Butler Drive</i>			
14. FATHER'S NAME First <i>CHARLES</i>	Middle <i>WILLIAMSON</i>	Lost <i>RUTH</i>	15. MOTHER'S MAIDEN NAME First <i>RUTH</i>	Address <i>CHARLES E. KIRBY DENTON</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>4129</i>	17. INFORMANT <i>CHARLES E. KIRBY</i>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF <i>4129</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Coronary atherosclerotic heart disease</i>				10 yrs			
(b) DUE TO, OR AS A CONSEQUENCE OF <i>Acute viral upper respiratory infection (flu).</i>							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Acute viral upper respiratory infection (flu).</i>							
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (<i>this hospital</i>) attended the deceased from <i>Sept 3, 1968</i> , to <i>22 Dec, 1968</i> , that (I) <i>never</i> last saw the deceased alive on <i>20 Dec 1968</i> , and that in <i>(my) (our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>never</i> (did) (did not) view the body after death.							
22b. SIGNATURE <i>Thurston Harrison</i>	22c. DEGREE <i>A.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>23 Dec 68</i>				
22d. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>	22e. ADDRESS <i>Easton, Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (Check)	23b. DATE <i>DEC. 23, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>DENTON</i>	23d. LOCATION (City or Town) <i>DENTON</i>	(County) <i>Ore. MD.</i>	(State)		
24. FUNERAL DIRECTOR <i>Charles V. Moore, Denton, Maryland</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>Charles J. Moore</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Moore</i>				
VR A&L 4 30M REV. 1-68		DATE DEC 27 1968					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18323

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First KATIE	Middle R.	Last KOENIG	2a. DATE OF DEATH Month December	Day 10	Year 1968	2b. HOUR 6 45 A.M.	
3. SEX FEMALE	4. RACE WHITE	S. DATE OF BIRTH 10-28-86	6. AGE (in years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 6	IF UNDER 24 HRS. MIN. 45		
7a. BIRTHPLACE (State or foreign country) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH TALBOT					
10. CITY OR TOWN OF DEATH EASTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOUSE IN THE PINES	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WORK	12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY TALBOT	13c. CITY OR TOWN EASTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 408 SOUTHWAY ST.				
14. FATHER'S NAME First William J. COLLINS	Middle	Last	15. MOTHER'S MAIDEN NAME First MARY EASTON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 230-28-4976	17. INFORMANT CARL H. KOENIG, CATONSVILLE, MD	Address CATONSVILLE, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA (Aspirated)</u>				<u>12/1/68</u>				
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable Carcinoma of STOMACH</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1519								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Esophagitis</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION 151X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/18/68</u> , 19, to <u>12/10/68</u> , 19, that (I) (we) last saw the deceased alive on <u>12/1/68</u> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Daniel D. Smith, MD</u>		DEGREE ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12/12/1968		23c. NAME OF CEMETERY OR CREMATORIAL SINKING HILL		23d. LOCATION (City or Town) EASTON, MD		
24. FUNERAL DIRECTOR Maurice L. Deurman		ADDRESS 300 EASTON, MD		25a. REC'D BY REGISTRAR DEC 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

20601

1960-1970

X

1960-1970

MARYLAND STATE DEPARTMENT OF HEALTH

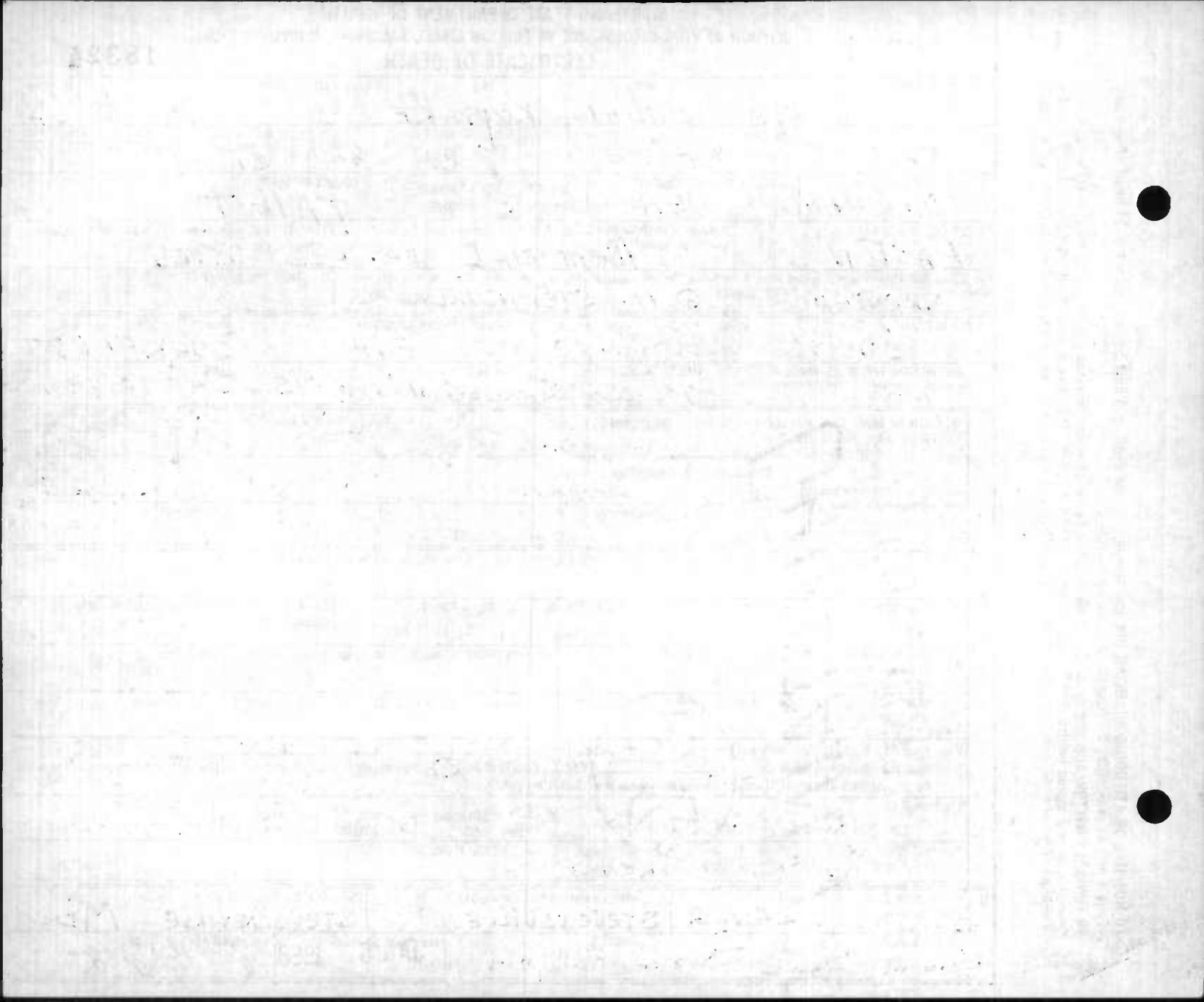
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

4
1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>JOSEPH</i>	Middle <i>William</i>	Lost	20. DATE OF DEATH Month <i>12</i> Day <i>30</i> Year <i>1968</i>	2b. HOUR <i>Cp M</i>		
3. SEX <i>MALE</i>	4. RACE <i>WHITE</i>	S. DATE OF BIRTH <i>FEB. 4 - 1887</i>	6. AGE (In years last birthday) <i>81</i> YRS.	5. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7b. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>TALBOT</i>				
10. CITY OR TOWN OF DEATH <i>EASTON</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>A.R.</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>	13b. COUNTY <i>Q. A. STEVENSVILLE</i>	13c. CITY OR TOWN <i>Q. A. STEVENSVILLE</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>XX</i>			
14. FATHER'S NAME First <i>JULIUS</i>	Middle <i>KOPINKE</i>	15. MOTHER'S MAIDEN NAME First Middle <i>EVA</i>	BURKHARDT	16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>< 1 week</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>705-05-2335</i>	17. INFORMANT <i>Jos. L. Kopinke = 1512 CRITTENDEN RD WILM. DEL</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>exposure</i> DUE TO, OR AS A CONSEQUENCE OF last. (c) <i></i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>< 1 week</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>493x</i>							
19a. DATE OF OPERATION <i>493x</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i></i>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>12-27</i> , 19 <i>65</i> , to <i>12-30</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12-29</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert W. Trevor M.D.</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>12-30-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>ROBERT W. TREVOR</i>		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>JAN. 2</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>STEVENSVILLE</i>	23d. LOCATION (City or Town) (County) <i>STEVENSVILLE MD.</i>	(State)			
24. FUNERAL DIRECTOR <i>Edgar L. Lane</i>	ADDRESS <i>Church Hill, Md.</i>	25a. REGD BY REGISTRAR DATE <i>JAN 6 1969</i>	25b. REGISTRAR'S SIGNATURE <i>please judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH												18325	
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR				
<i>Clarence Cannon Lord</i>						Month	Day	Year	Hour	Min.			
3. SEX	Male	4. RACE	White	S. DATE OF BIRTH	June 19, 1893	6. AGE (In years last birthday)	75	IF UNDER 1 YEAR YRS.	IF UNDER 24 HRS. MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.	
7a. BIRTHPLACE (State or foreign country)	Md.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH	Talbot	Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Eastern			Memorial			Retired Farmer			None				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Queen Anne	13c. CITY OR TOWN	Queen Anne	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	x	13e. STREET AND NUMBER	None				
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last										
James Lord			Martha Cannon										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)	No	16b. SOCIAL SECURITY NO.	181-05-1235	17. INFORMANT	Address Beulah Lord Queen Anne, Maryland								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis - (R) hemiplegia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>days</i>													
433.9 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic obstructive lung disease</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <i>12 Dec 68</i> , to <i>19 Dec 68</i> , that (I) (we) last saw the deceased alive on <i>14 Dec 68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Newton Harrison M.D.</i>		22c. DEGREE DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.			22c. DATE SIGNED <i>16 Dec 68</i>								
22d. PHYSICIAN'S NAME (Type) <i>NEWTON HARRISON</i>		22e. ADDRESS <i>Eaton Maryland</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-17-68			23c. NAME OF CEMETERY OR CREMATORIAL Greensboro			23d. LOCATION (City or Town) Greensboro, Maryland		(County)		(State)	
24. FUNERAL DIRECTOR <i>John E. Boulaia</i>		ADDRESS <i>Greensboro, NC</i>			25a. REC'D BY REGISTRAR DATE DEC 18 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

68041

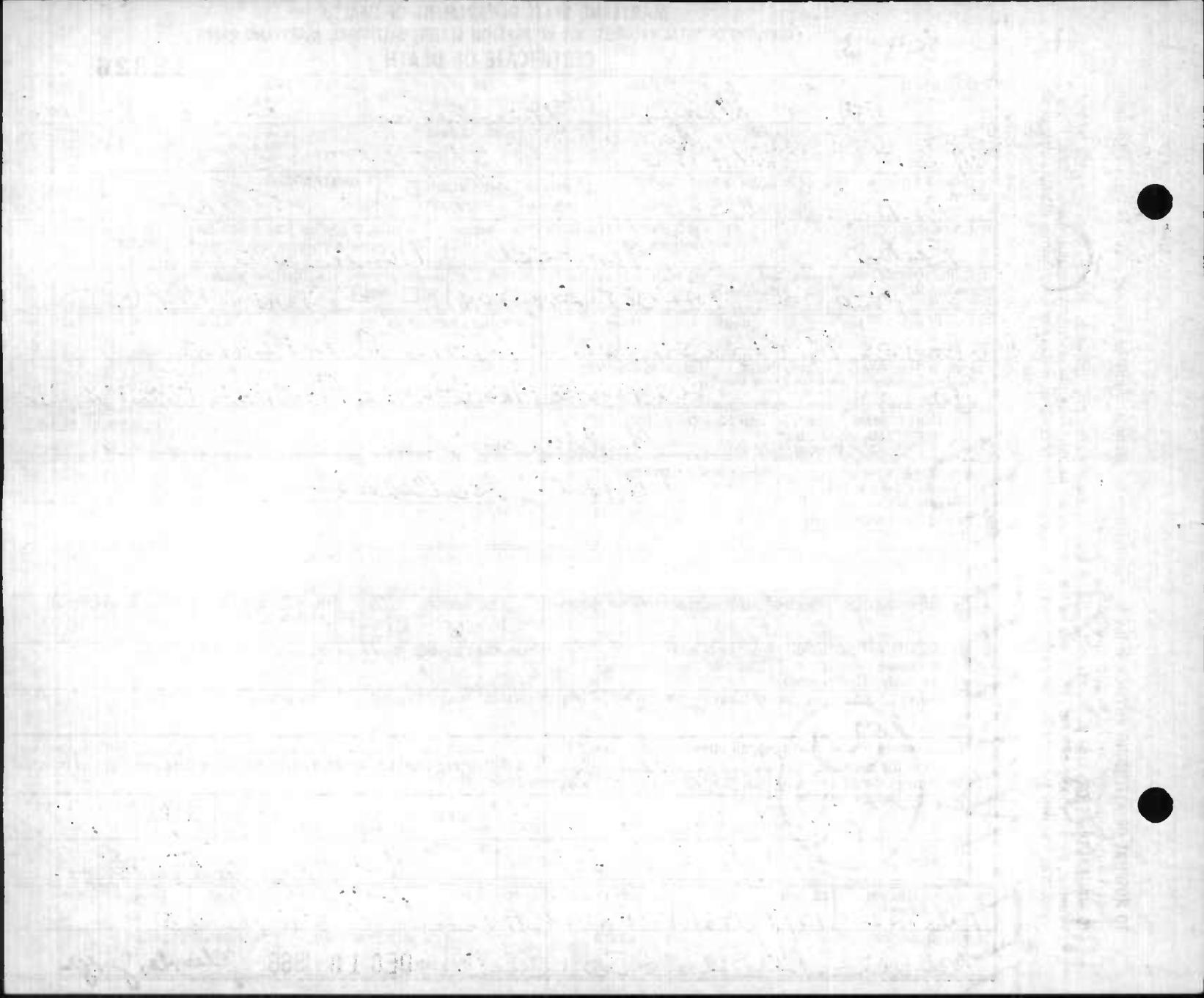
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Lost	2. DATE OF DEATH Month	Day	Year	2b. HOUR 10A M	
3. SEX		4. RACE		S. DATE OF BIRTH	6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH		Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
EASTON		Memorial		FIRENT LIFE INS					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
MD		LALBOT EASTON		NO		STONEY RIDGE			
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost	
JAMES R. PHARSHALL					LIDIA CHAPLIN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		312-18-6438		MRS. GEORGE PHARSHALL, EASTON, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart disease</u> 492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary occlusion.</u> (c)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
5271									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED 12/10/1968							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
E-C-H. Schrieff		18313							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County) (State)	
12/10/1968		12/10/1968		SPRING HILL		EASTON, MD			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Maurice E. Newnam & Son EASTON				DEC 10 1968		Charles Judge			
VR A 1544 30M REV 1/68									



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

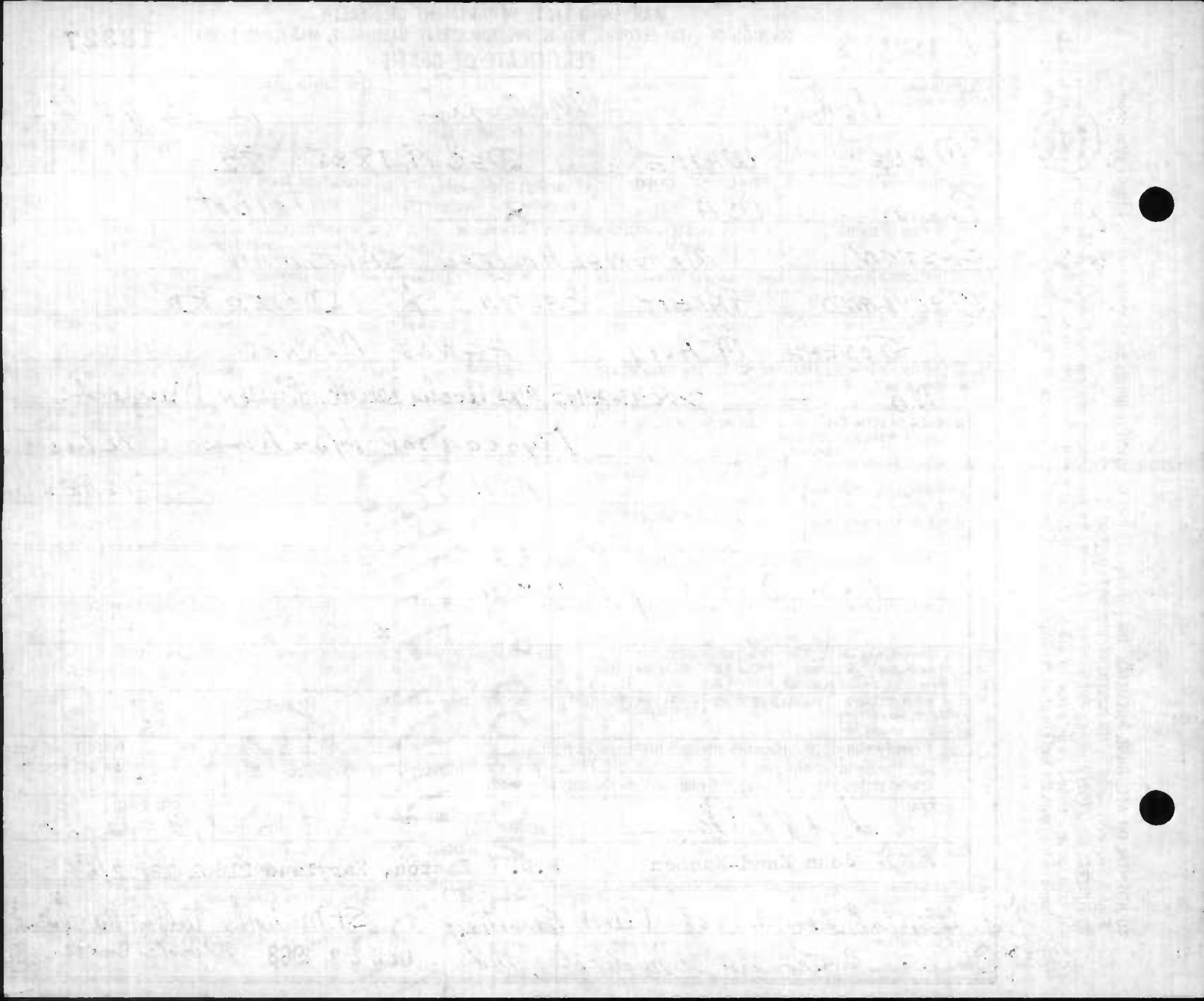
Page 4 may be retained by the hospital or attending physician.
10 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please sign and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18327

1. DECEASED-NAME (Type or print)	First <i>John</i>	Middle <i></i>	Last <i>McAvoy</i>	2a. DATE OF DEATH Month <i>12</i>	Day <i>12</i>	Year <i>68</i>	2b. HOUR <i>6:25 A.M.</i>		
3. SEX <i>MALE</i>	4. RACE <i>WHITE</i>	S. DATE OF BIRTH <i>DEC 19, 1885</i>	6. AGE (in years last birthday) <i>82</i> YRS.	IF UNDER 1 YEAR MONTHS <i></i>	IF UNDER 24 HRS. HOURS <i></i>	IF UNDER 24 HRS. MIN. <i></i>			
7a. BIRTHPLACE (State or foreign country) <i>Penn.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Talbot</i>	Md.					
10. CITY OR TOWN OF DEATH <i>EASTON</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MEMORIAL HOSPITAL</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>SALES MAN</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>	13b. COUNTY <i>TALBOT</i>	13c. CITY OR TOWN <i>EASTON</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>DOVER RD</i>					
14. FATHER'S NAME First <i>JOSEPH</i>	Middle <i></i>	Last <i>McAvoy</i>	15. MOTHER'S MAIDEN NAME First <i>AGNES NORRIS</i>	Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>218-12-4913</i>	17. INFORMANT <i>Mrs Cecelia Deuell, Easton, Maryland</i>	Address <i></i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4109</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs -</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASH D</i>				YEARS <i></i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i></i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>4201 iron deficiency anemia</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								22c. DATE SIGNED <i>12-12-68</i>	
22b. SIGNATURE <i>John Knud-Hansen</i>		DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.						
22d. PHYSICIAN'S NAME (Type) <i>John Knud-Hansen</i>		22e. ADDRESS <i>Easton, Maryland 21601</i>	22f. DATE <i>12/12/68</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Dec 14, 1968</i>		23b. DATE <i></i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Oliver Cemetery</i>		23d. LOCATION (City or Town) <i>St. Michaels Talbot Maryland</i>		(County) (State)		
24. FUNERAL DIRECTOR <i>Hanson & Leonard St. Michaels, Md</i>		ADDRESS <i></i>	25a. REC'D BY REGISTRAR DATE <i>DEC 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

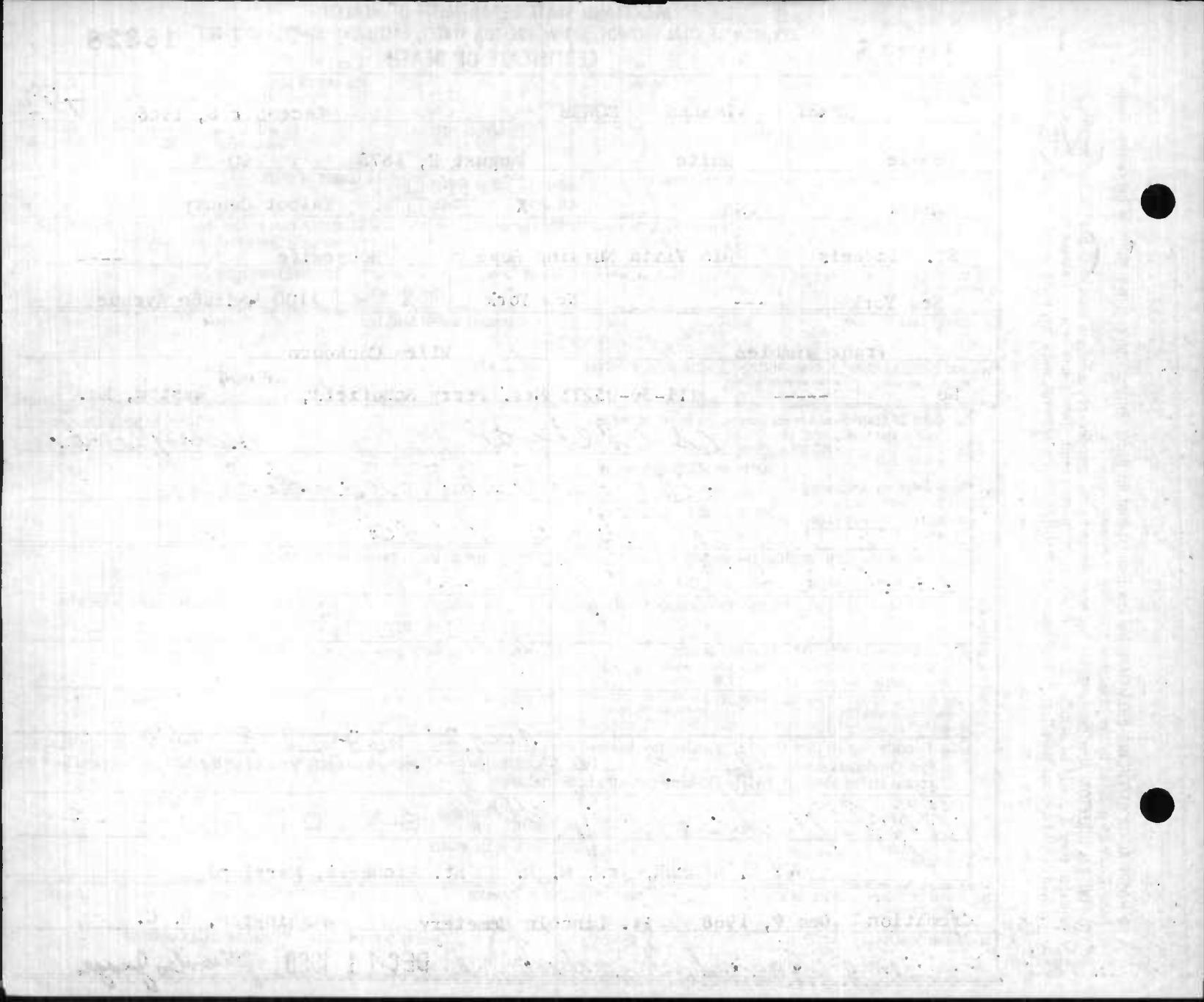
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18328

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove or tear off papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First JANET	Middle WIMBLES	Last MORSE	2a. DATE OF DEATH Month December	Day 8, 1968	Year 1968	2b. HOUR 7 A.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH August 2, 1878			6. AGE (In years last birthday) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Canada	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Talbot County			Md.		
10. CITY OR TOWN OF DEATH St. Michaels	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rio Vista Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY ---			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE New York	13c. CITY OR TOWN New York	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 1100 Madison Avenue					
14. FATHER'S NAME First Frank Wimbles	Middle 	Last 	15. MOTHER'S MAIDEN NAME First Ellen Cockburn	Middle 	Last 			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) -----	17. INFORMANT RFD # Mrs. Perry Schofield,	Address Easton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral</u> <u>meningitis</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause lost. 4221 (b) <u>atherosclerotic cardiac</u> <u>x</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cerebro vascular</u>								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>cardiac & renal failure</u>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from Aug 21, 1968, to 12-8, 1968, that (I) (we) last saw the deceased alive on 12-8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Guy M. Reeser, Jr., M.D.</u>	22c. DATE SIGNED 12-8-68	ATTENDING DEGREE PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.				
22d. PHYSICIAN'S NAME (Type) GUY M. REESER, JR., M. D.	22e. ADDRESS St. Michaels, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE Dec 9, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery	23d. LOCATION (City or Town) Washington, D. C.	(County)	(State)			
24. FUNERAL DIRECTOR Harrison E. Leonard, St. Michaels Md.	ADDRESS 	25a. REC'D BY REGISTRAR DEC 11 1968	25b. REGISTRAR'S SIGNATURE Charles Judge					



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 4 and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18316

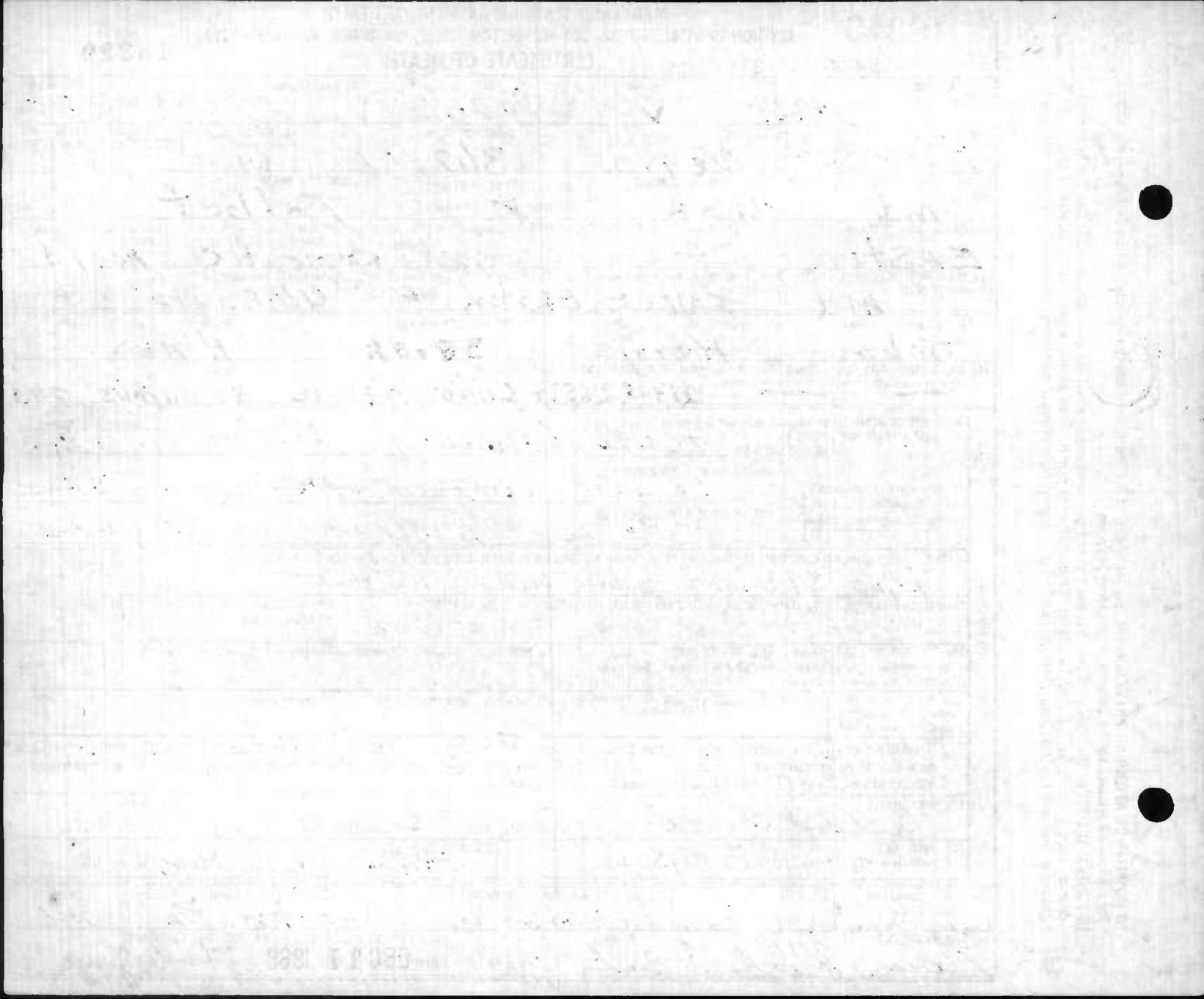
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 11 Film G407 12/23/68 kk

CERTIFICATE OF DEATH

18329

1. DECEASED NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 8:15 AM
MARY	V	Powell		DEC 11 1968	
3. SEX	RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female	Negro	3/17/01	67 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	9. COUNTY OF DEATH	12b. KIND OF BUSINESS OR INDUSTRY	
md	USA	NEVER MARRIED DIVORCED	Talbot	Domestic Maid	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
EASTON	Easton Memorial Hospital			Domestic	Maid
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
md	Talbot	EASTON	YES <input checked="" type="checkbox"/>	410 South St	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	Address
John	Harris			Sarah	Lillie Harris Indianapolis 2nd
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
—	213-22-6593	Lillie Harris	1-2 hrs		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) CONGENITAL CONGESTIVE HEART DISEASE 3 yrs.					
DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE LEFT VENTRICULAR FAILURE 1-2 hrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) LONG STANDING BRONCHIAL ASTHMA					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
MEDICAL CERTIFICATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
While at work	AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No. City or Town County State			
at work					
22a. I certify that (I) (this hospital) attended the deceased from JULY 1965, to 12-11-1968, that (we) last saw the deceased alive on DEC 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard L. Tyson, MD	22c. DATE SIGNED 12-11-68				
22d. PHYSICIAN'S NAME (Type) RICHARD L. TYSON	22e. ADDRESS EASTON 21601 MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec 14 1968	23c. NAME OF CEMETERY OR CREMATORIAL Richards	23d. LOCATION (City or Town) EASTON TA.	(County)	(State)
24. FUNERAL DIRECTOR Deans & Daubell	ADDRESS EASTON 2nd	25a. REC'D BY REGISTRAR DATE DEC 17 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18330

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR
		Barline Jones President			Dec. 25 1968			1140	
3. SEX Female	4. RACE C	S. DATE OF BIRTH Oct. 19, 1934	6. AGE (in years lost birthday) 34 yrs.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.		
7a. BIRTHPLACE (State or foreign country) Norfolk, Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Press Operator-Maryland Plastics			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13c. CITY OR TOWN Caroline		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.F.D.			
14. FATHER'S NAME First Christopher C. Jones		Middle	Last	15. MOTHER'S MAIDEN NAME First Anzie Reid		Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 229-38-1457		17. INFORMANT John President, Federalsburg, Maryland, RFD		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumothorax & hemothorax								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours	
DUE TO, OR AS A CONSEQUENCE OF (b) Fracture of Sternum & ribs & runture of liver									
DUE TO, OR AS A CONSEQUENCE OF (c) Automobile accident									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Results of Complete Autopsy As yet Or Blood Alcohol									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. MEDICAL CERTIFICATION PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR AM 12:40 P.M. 12/24/68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Car out of control ran off road & hit trees					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Laurel Grive Road		21f. LOCATION Street or R.F.D. No. RFD Federalsburg		City or Town Caroline		County Maryland	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Harold B. Plummer</i>		EXAMINER'S NAME (Type) Harold B. Plummer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 12/24/68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 29, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Johns Cemetery		23d. LOCATION (City or Town) Near Preston, Maryland		(County) (State)	
24. FUNERAL DIRECTOR Frampton Funeral Home		ADDRESS Federalsburg, Maryland		25a. RECEIVED BY REGISTRAR JAN 13 1969		25b. APPROVED AND SIGNED Harold B. Plummer			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18331

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. It can please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First W.	Middle MITCHELL	Lost PRICE	20. DATE OF DEATH 12 Month 16 Day 68 Year 8:50 A.M.	2b. HOUR 2b. HOUR
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 3-13-1890		6. AGE (In years last birthday) 78	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH TALBOT			
10. CITY OR TOWN OF DEATH EASTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOUSE IN THE PINES	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY BLDG CONTRACTOR		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY TALBOT	13c. CITY OR TOWN EASTON	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
14. FATHER'S NAME First W.M.	Middle Booth	Lost PRICE	15. MOTHER'S MAIDEN NAME First GEORGIA WEY ROUGH	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Mrs W. MITCHELL PRICE	Address EASTON MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Starvation 1419 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1419				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks		
(b) Hemiglossectomy radical neck dissection DUE TO, OR AS A CONSEQUENCE OF (c) for cancer of the tongue				3 weeks		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Gastroesophageal reflux disease and abdominal arteriovenous malformations						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from 12-2-68 , 19_____, to 12-16- , 19_____, that (I) (we) last saw the deceased alive on 12-14-68 , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Sophie O'Clough	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	<input type="checkbox"/>	22c. DATE SIGNED 12-18-68	
22d. PHYSICIAN'S NAME (Type) S.P. CLOUGH	22e. ADDRESS EASTON, MD					
23a. BURIAL/CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 12-20-68	23c. NAME OF CEMETERY OR CREMATORIAL SPRING HILL	23d. LOCATION (City or Town) EASTON TA MD	(County)	(State)	
24. FUNERAL DIRECTOR John Clark	ADDRESS EASTON, MD	25a. REC'D BY REGISTRAR DATE DEC 23 1968	25b. REGISTRAR'S SIGNATURE John Clark			

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1 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

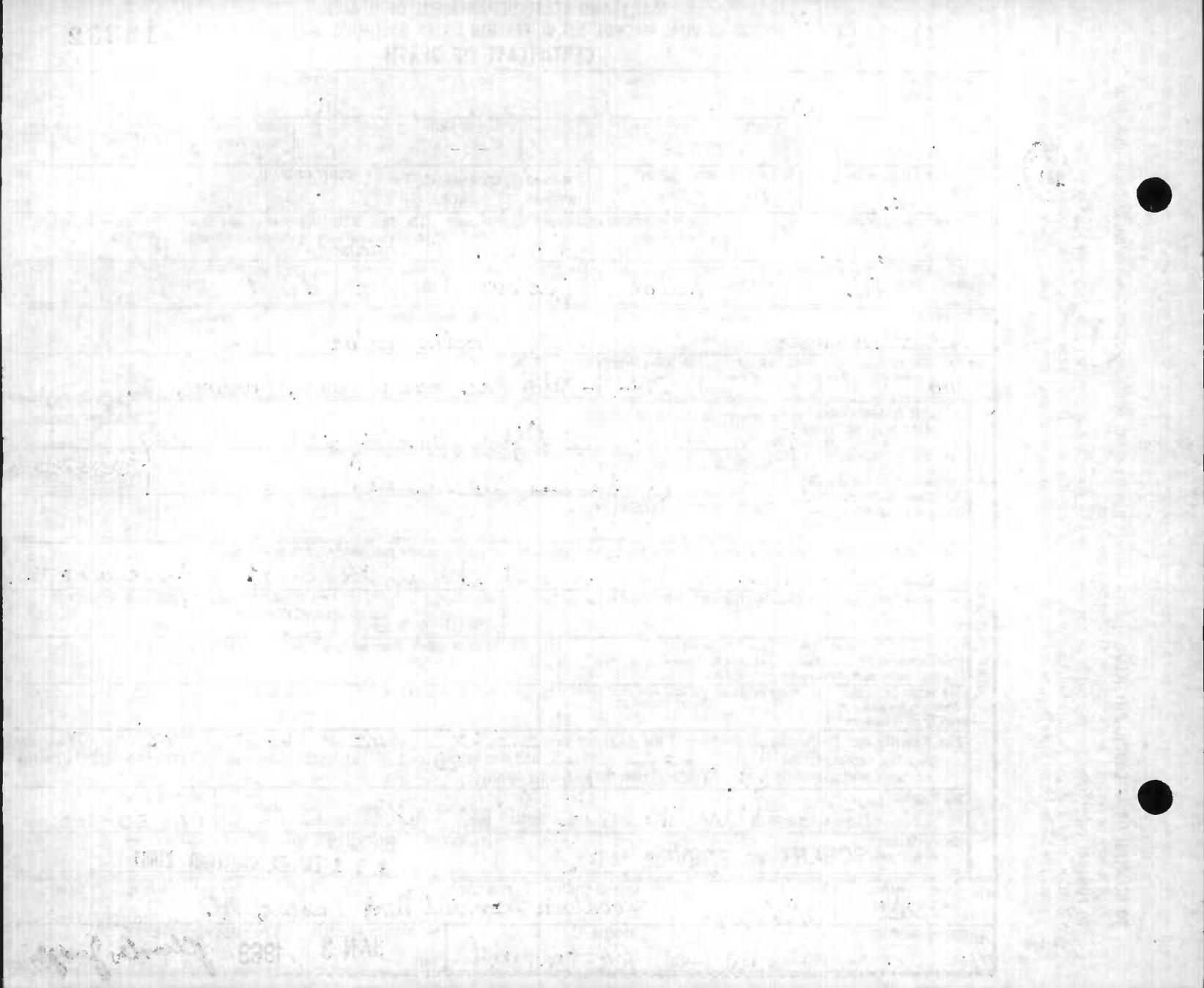
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Boxes 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18319

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

18332

1. DECEASED NAME (Type or print)	First Samuel	Middle D.	Last Royer	2a. DATE OF DEATH Month Dec.	Day 30	Year 1968	2b. HOUR 5 ¹⁰ M	
3. SEX male	4. RACE white	5. DATE OF BIRTH 5-6-83	6. AGE (In years last birthday 85 YRS.)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.	
7a. BIRTHPLACE (State or foreign country) Pa.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Talbot	Md.				
10. CITY OR TOWN OF DEATH Easton, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House in The Pines			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Talbot	13c. CITY OR TOWN Cordova	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rd #1				
14. FATHER'S NAME Matthew Royer	First	Middle	Last	15. MOTHER'S MAIDEN NAME Amelia Dundon	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-34-39621	17. INFORMANT Mrs. Samuel Royer, Cordova, Md.	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pseudobulbar palsy</u> 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis 4500 (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Uncertain		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Carcinoma of the prostate with obstructive uropathy</u>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <u>1-25</u> , 19 <u>65</u> , to <u>12-30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-25</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Robert W. Trever		DEGREE ATTENDING PHYS.	22c. DATE SIGNED 12-30-68					
22d. PHYSICIAN'S NAME (Type) ROBERT W. TREVER, M.D.		22e. ADDRESS DUTCHMAN'S LANE ADO U. S. ROUTE 33 R. D. 3, EASTON, MARYLAND 21601						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/2/1969	23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Memorial Park	23d. LOCATION (City or Town) Easton, Md.	(County)		(State)		
24. FUNERAL DIRECTOR Maurice E. Deerman, Son	ADDRESS Easton, Md.	25a. REC'D BY REGISTRAR DATE JAN 3 1969	25b. REGISTRAR'S SIGNATURE Charles Judge					

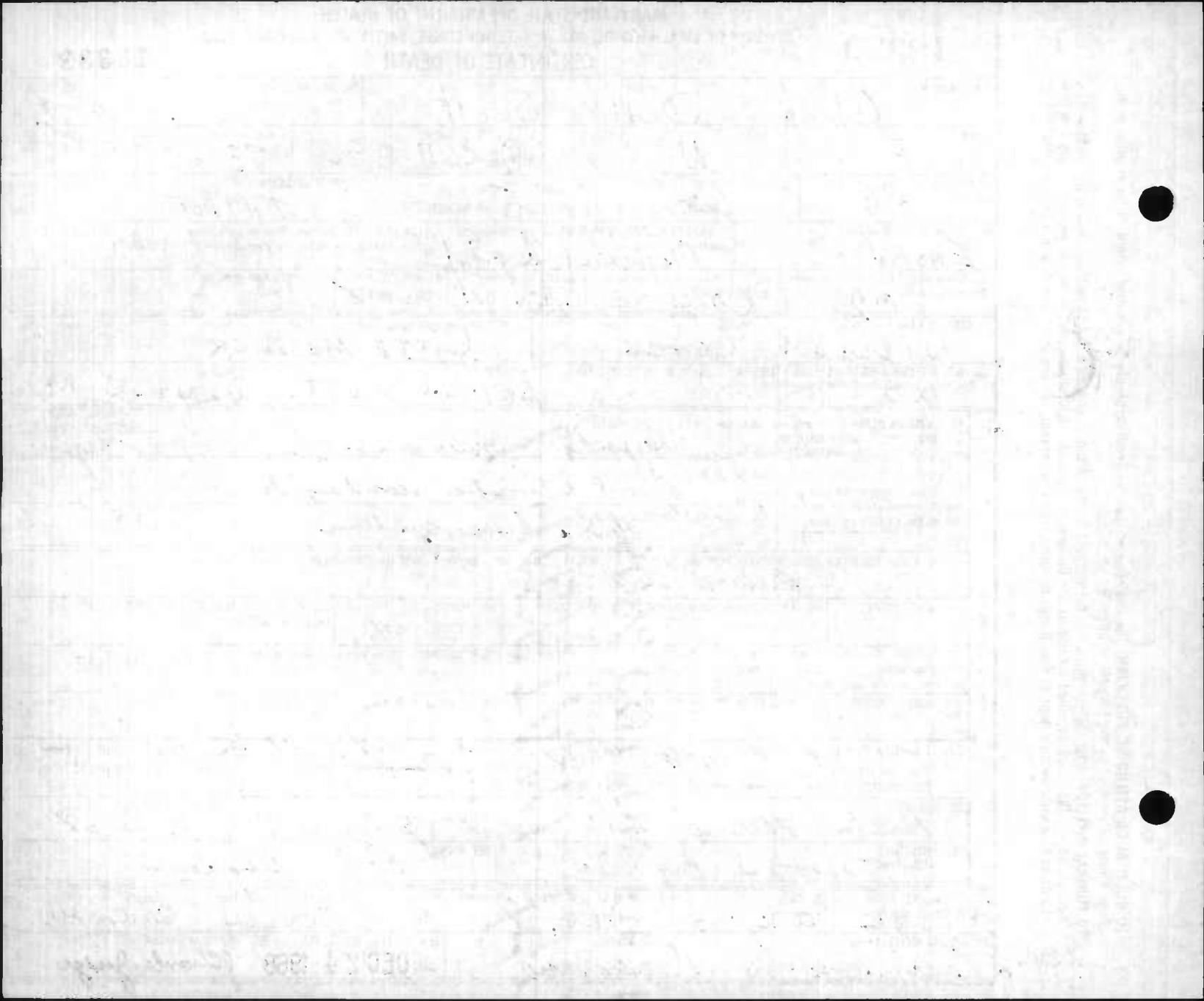


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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician. Then please remove carbon papers. Page 1 and 2
 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2
 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

CERTIFICATE OF DEATH

18320	CERTIFICATE OF DEATH										18333
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2. DATE OF DEATH			2b. HOUR		
<i>CLARA</i>			<i>Dell</i>	<i>Scott</i>		Month	Day	Year	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS	MIN
3. SEX			4. RACE	W	5. DATE OF BIRTH	DEC. 11, 1890			6. AGE (In years last birthday) YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED	NEVER MARRIED	WIDOWED	DIVORCED	9. COUNTY OF DEATH		
MD			<i>USA</i>						<i>Talbot</i>		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
<i>EASTON</i>			<i>Memorial Hosp. tal</i>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
MD			<i>CAROLINE DENTON</i>								
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
<i>WILLIAM CONIGREE</i>						<i>KATIE MESSICK</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No						<i>ARTHUR SCOTT</i>			<i>DENTON, MN</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypostatic pneumonia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> <i>3099</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>General deterioration secondary to</i> (c) <i>Chronic brain syndrome</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>3099</i> <i>Diabetes mellitus</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>1 Dec</i> , 1968, to <i>19 Dec</i> , 1968, that (I) (we) last saw the deceased alive on <i>16 Dec</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Thurston Harrison MD</i> DEGREE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22c. DATE SIGNED <i>19 Dec 68</i>											
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
<i>THURSTON HARRISON</i>		<i>Easton, Maryland</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town)		(County)	(State)	
<i>Burial</i>		<i>Dec 20, 1968</i>		<i>Denton</i>			<i>Denton</i>		<i>Car</i>	<i>MD.</i>	
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<i>Charles V. Moore Son, Denton, Md.</i>						<i>DEC 24 1968</i>		<i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

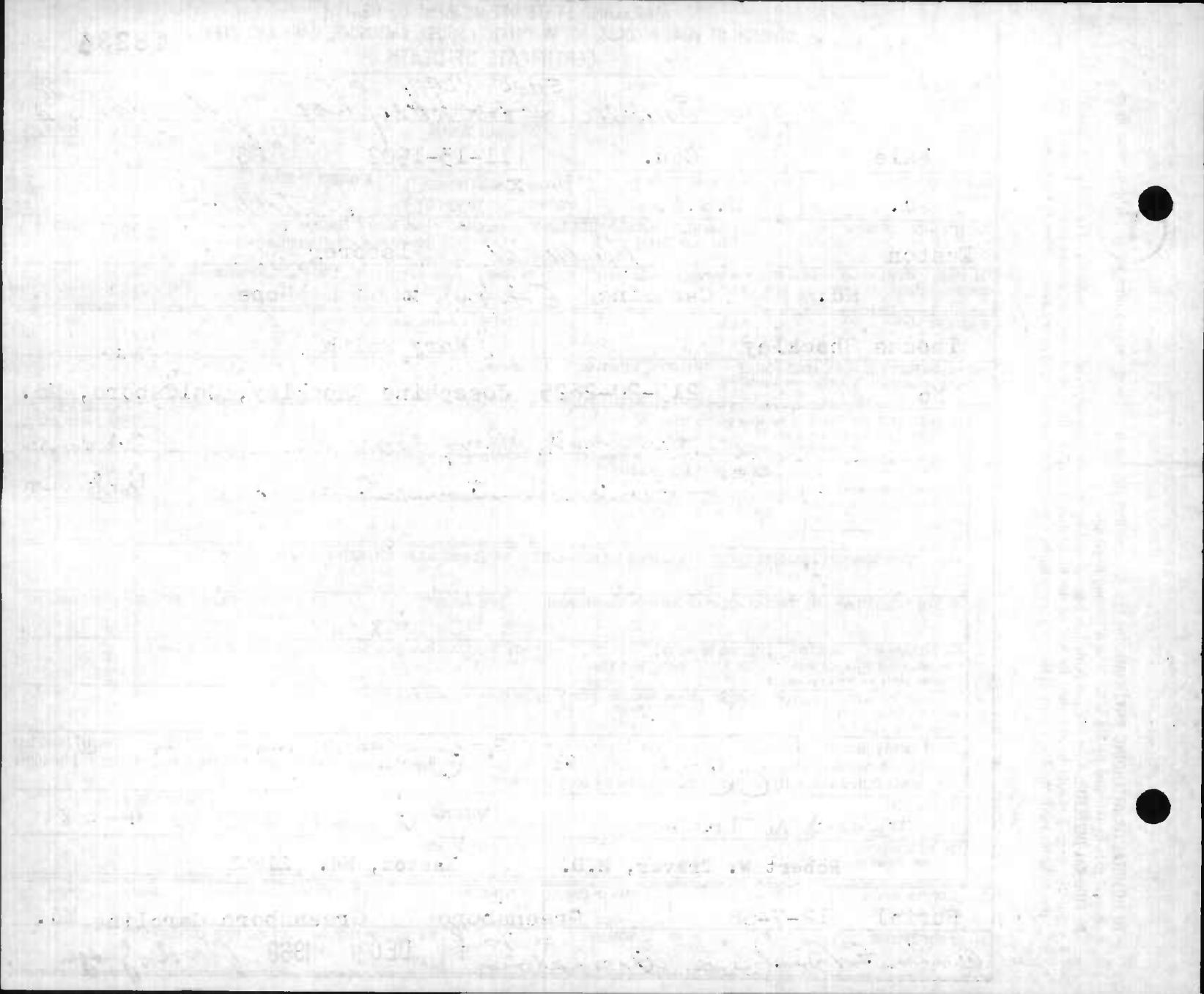
18334

CERTIFICATE OF DEATH

4 13
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First <i>William</i>	Middle <i>Smith</i>	Last <i>Shockley</i>	2a. DATE OF DEATH Month Year Day Year <i>Dec. 4 1968</i>	2b. HOUR <i>3 1/4 A.M.</i>		
3. SEX <i>Male</i>	4. RACE <i>Cau.</i>	S. DATE OF BIRTH <i>11-13-1902</i>	6. AGE (In years last birthday) <i>66</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Talbot</i>				
10. CITY OR TOWN OF DEATH <i>Easton</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Laborer</i>	12b. KIND OF BUSINESS OR INDUSTRY <i></i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Caroline</i>	13c. CITY OR TOWN <i>Easton</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>None</i>			
14. FATHER'S NAME <i>Thomas Shockley</i>	First Middle Last	15. MOTHER'S MAIDEN NAME <i>Mary Smith</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>215-20-2625</i>	17. INFORMANT <i>Josephine Shockley, Goldsboro, Md.</i>	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>				
4339 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Unknown</i>							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral arteriosclerosis</i>			Unknown				
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>332X</i>							
19a. DATE OF OPERATION <i>332X</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <i></i>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>			
21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i>		21f. LOCATION Street or R.F.D. No. <i></i>	City or Town <i></i>	County <i></i>	State <i></i>
22a. I certify that (I) (this hospital) attended the deceased from <u>12-2</u> , 19 <u>68</u> , to <u>12-4</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12-3</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED <i>12-4-68</i>	
22b. SIGNATURE <i>Robert W. Trever</i>		DEGREE <i></i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type) <i>Robert W. Trever, M.D.</i>		22e. ADDRESS <i>Easton, Md. 21601</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-7-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Greensboro</i>	23d. LOCATION (City or Town) <i>Greensboro</i>	(County) <i>Caroline</i>	(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>John E. Bowles Greensboro</i>		ADDRESS <i>2nd</i>	25a. RECEIVED BY REGISTRAR DATE <i>DEC 9 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



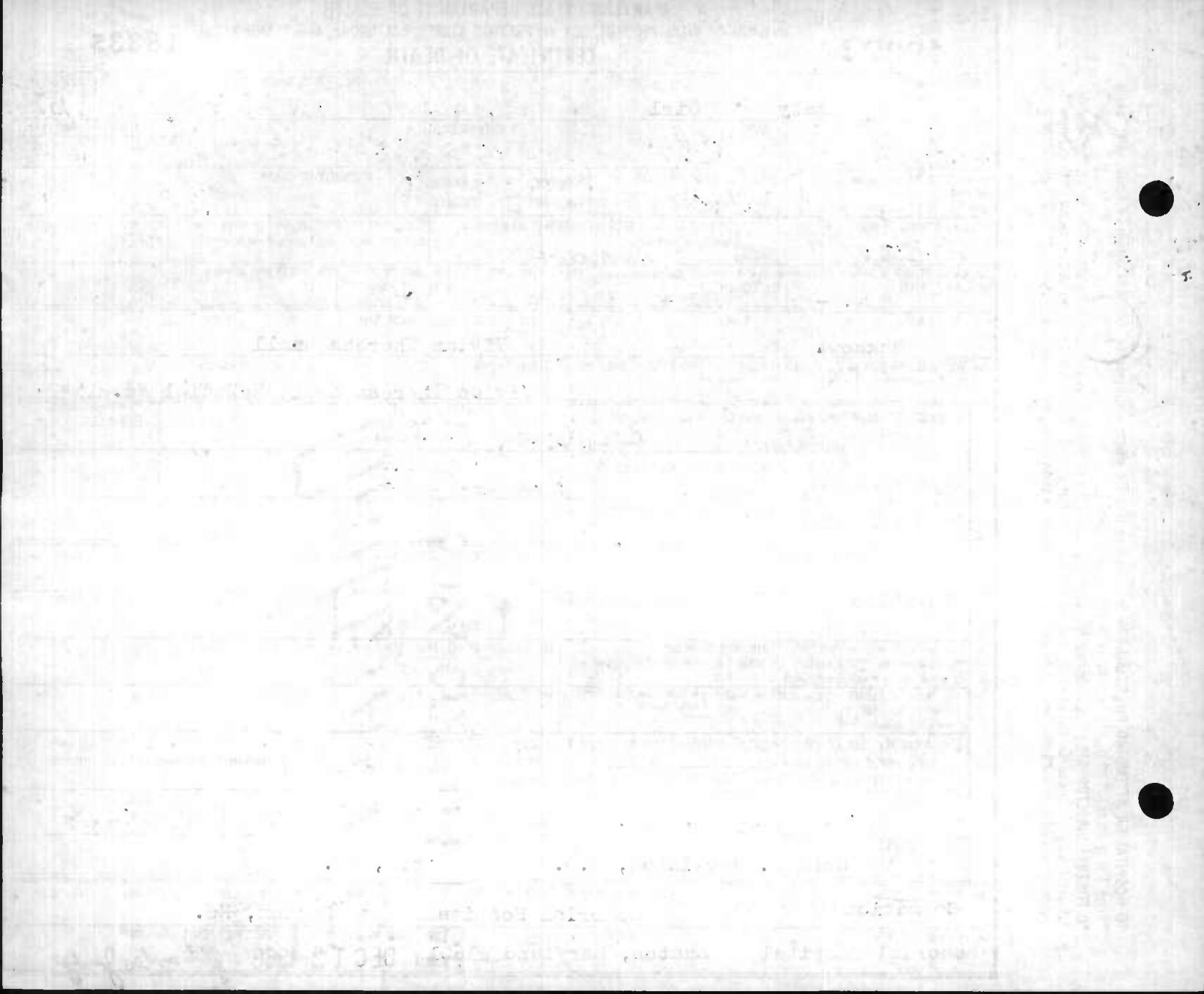
CERTIFICATE OF DEATH

18335

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Baby	Middle Girl	Last SMALL	2d. DATE OF DEATH Month 12 - 4 - 68	Year 68	2b. HOUR 10 AM		
3. SEX Female	4. RACE Col	S. DATE OF BIRTH 12-3-68	6. AGE (In years lost birthday) — YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.	
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH TALBOT	Md.				
10. CITY OR TOWN OF DEATH EASTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial L	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. -	13b. COUNTY Talbot	13c. CITY OR TOWN McDaniel	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER				
14. FATHER'S NAME First Unknown	Middle	Last	15. MOTHER'S MAIDEN NAME First Vivian Theresa Small	Middle	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Vivian Theresa Small McDaniel Md. 21647	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
776.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Prematurity								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o) 7735								
19a. DATE OF OPERATION 2	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) MEMORIAL HOSPITAL	21f. LOCATION Street or R.F.D. No. McDaniel	City or Town Easton	County Talbot	State		
22a. I certify that (I) (this hospital) attended the deceased from 12-3 - 1968 , to 12-4 - 1968 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE John A. Hawkinson		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 12-9-68		
22d. PHYSICIAN'S NAME (Type) John A. Hawkinson, M.D.		22e. ADDRESS Easton, Md.						
23a. BURIAL, CREMATION Cremation		23b. DATE 12/7/1968	23c. NAME OF CEMETERY OR CREMATORIAL Memorial Hospital	23d. LOCATION (City or Town) Easton, Md.	(County) Talbot	(State) Md.		
24. FUNERAL DIRECTOR Memorial Hospital		ADDRESS Easton, Maryland 21601	25a. REC'D BY REGISTRAR DATE DEC 12 1968	25b. REGISTRAR'S SIGNATURE J Charles Judge				



18323

18336

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR 24 HRS. M
William Francis Smith				12 6 68	7:55
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) YRS.	IF UND. 1 YEAR MONTHS DAYS HOURS MIN.	
Male	Negro	6/1/1899	69		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	9. COUNTY OF DEATH		
Md.	U.S.A.	<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED	Talbot		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Easton	Memorial			General Del.	None
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Md. Caroline	Gore		General Del.		
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First
David Smith				Sophronia Carter	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address		
No	218165218A	Rome Rooney, Md.	Dentist		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, rt. lower lobe DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic alcoholism DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH >9 days Uncertain					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
3221					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 11-28, 1968, to 12-6, 1968, that (I) (we) last saw the deceased alive on 12-6, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	Robert W. Trevor		DEGREE	ATTENDING PHYS.	22c. DATE SIGNED 12-6-68
22d. PHYSICIAN'S NAME (Type)	Robert W. Trevor		22e. ADDRESS Easton, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 12/10/68	23c. NAME OF CEMETERY OR CREMATORIAL Union	23d. LOCATION (City or Town) Goldsboro, Caroline, Md.	(County)	(State)
24. FUNERAL DIRECTOR	ADDRESS Charles Wolf, Denton, Md.	25a. REC'D BY REGISTRAR DEC 9 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		

800 0030

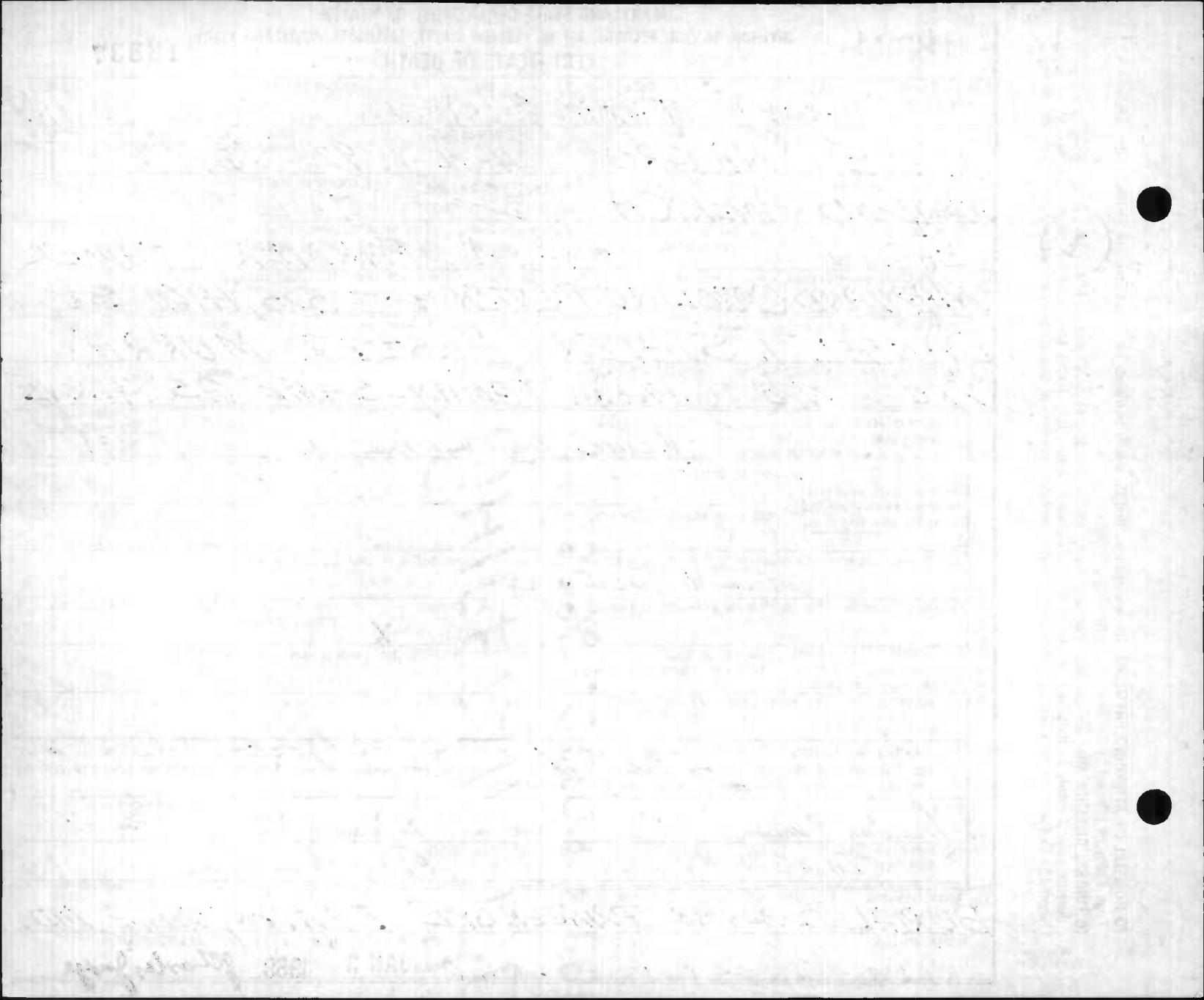
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18337

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
11 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Paper 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>DANIEL</i>	Middle <i>THOMAS</i>	Last <i>STATEN</i>	2d. DATE OF DEATH Month <i>12 - 30 - 1968</i>	Year <i>1968</i>	2b. HOUR <i>11 A.M.</i>		
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (In years lost birthday) <i>76 yrs.</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 4 HRS. DAYS <i>0</i>		
7b. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>AMERICA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>TALBOT</i>				
10. CITY OR TOWN OF DEATH <i>EASTON</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MEMORIAL</i>		12a. USUAL OCCUPATION (Kind of work done during past 2 years or life if never retired.) <i>FARMER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>FARMER</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>MARYLAND PROLINE DENTON</i>		13b. CITY OR TOWN <i>PROLINE</i>	13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <i>525, HIGH ST.</i>				
14. FATHER'S NAME <i>DANIEL T. STATEN</i>		15. MOTHER'S MAIDEN NAME <i>HESTER MURRAY</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		16b. SOCIAL SECURITY NO. <i>UNKNOWN</i>	17. INFORMANT <i>FAMILY-SAME AS ABOVE</i>					Address	
									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>(?)</i>
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Armenia, cause undetermined</i> <i>485X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Armenia, cause undetermined</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Armenia, cause undetermined</i></p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>491X</i> <i>Armenia, cause undetermined</i></p>									
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
<p>22a. I certify that (I) (this hospital) attended the deceased from <i>26 Dec., 1968</i>, to <i>26 Dec., 1968</i>, that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <i>26 Dec., 1968</i>, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did (did not) view the body after death.</p> <p>22b. SIGNATURE <i>Thurston Harrison MD.</i></p> <p>22d. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i></p> <p>22e. ADDRESS <i>Eastern Maryland</i></p> <p>22c. DATE SIGNED <i>28 Dec 68</i></p>									
23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i>		23b. DATE <i>12-30-1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>SPRINGER OYE</i>		23d. LOCATION (City or Town) <i>DETON CAROLINE, MD.</i>		(County) (State)		
24. FUNERAL DIRECTOR <i>Virgil Moore & Son - Denton Md.</i>		ADDRESS		25a. RECD BY REGISTRAR DATE JAN 3 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18325

18338

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Edna N. Summers</i>	Middle	Lost	20. DATE OF DEATH 12 Month 24 Day 1968 Year	2b. HOUR 3:55 P.M.
3. SEX <i>Female</i>	4. RACE <i>White</i>	S. DATE OF BIRTH <i>1/26/1890</i>	6. AGE (In years last birthday) <i>78</i>	IF UNDER 1 YEAR YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.
7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Talbot</i>			
10. CITY OR TOWN OF DEATH <i>St. Michaels (rural) Rio Vista Nursing Home</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Housework</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housework</i>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Talbot</i>	13c. CITY OR TOWN <i>Easton</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>307 S. Washington St</i>	
14. FATHER'S NAME First <i>John Neunam</i>	Middle	Last	15. MOTHER'S MAIDEN NAME First <i>Ida Robinson</i>	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	16b. SOCIAL SECURITY NO. <i>214-32-5295B</i>	17. INFORMANT <i>J. Russell Summers, Easton, Md.</i>	Address <i>months</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cachexia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>atherosclerotic cardio & cerebro Vas d</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>atherosclerotic cardio & cerebro Vas d</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>cerebro Vas d</i>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
4221		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
MEDICAL CERTIFICATION		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town
22a. I certify that (I) (this hospital) attended the deceased from <i>7-19-1967</i> , to <i>12-24-1968</i> , that (I) (we) last saw the deceased alive on <i>12-24-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Guy M. Reeser Jr. MD</i>		22c. DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>12-31-68</i>
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>Michael J. Michael Jr. MD</i>			
23a. BURIAL, CREMATION, REMANUFACTURE <i>Burial</i>	23b. DATE <i>12/27/1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Spring Hill</i>	23d. LOCATION (City or Town) <i>Easton, Md.</i>	(County)	(State)
24. FUNERAL DIRECTOR ADDRESS <i>Maurice E. NEUNAM & SON, Easton, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>JAN 2 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH

18326 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

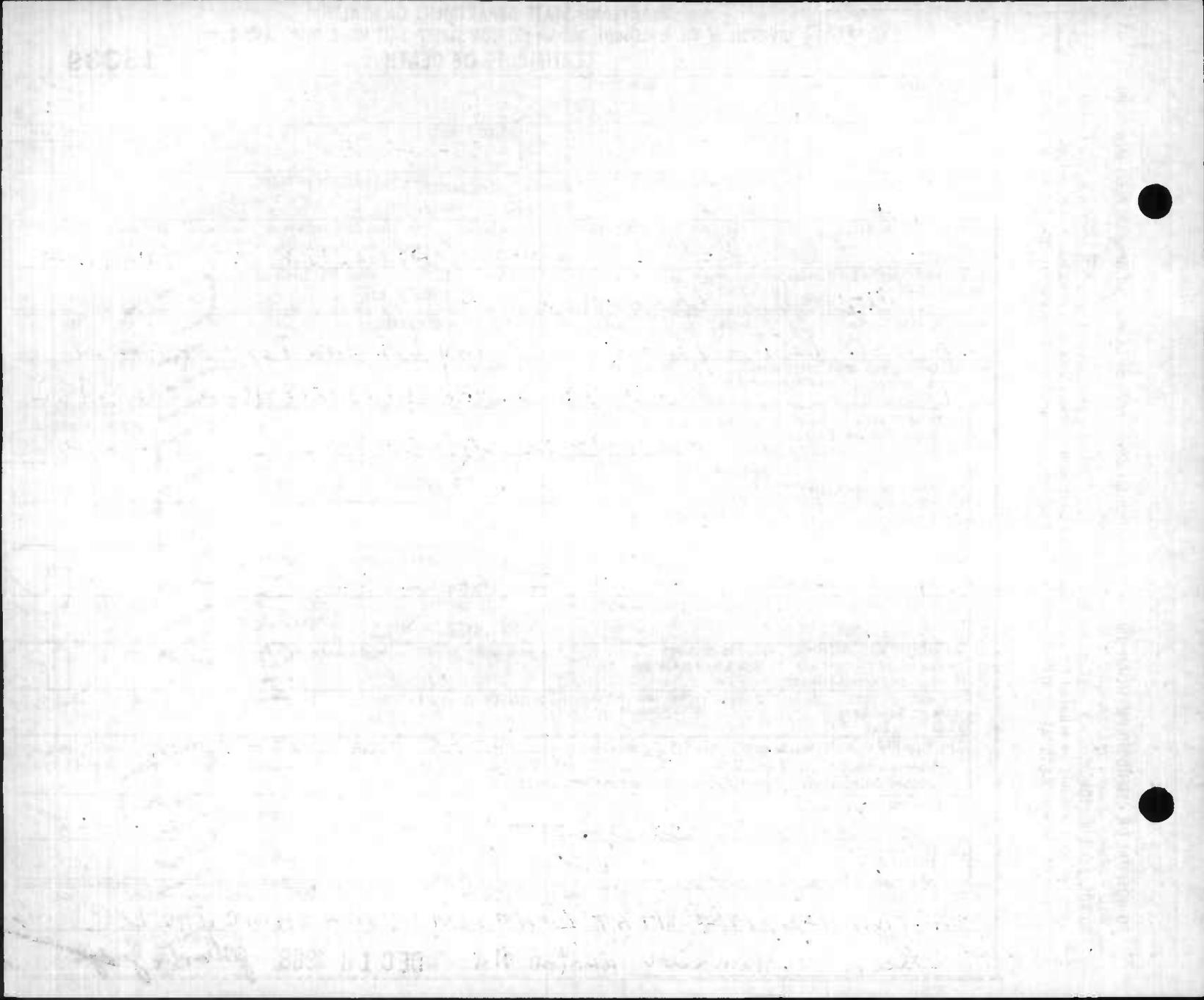
CERTIFICATE OF DEATH

18339

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Thomas	Middle Taylor	Last Taylor	2d. DATE OF DEATH 12 Month 7 Day 68 Year	2b. HOUR 7:20
3. SEX Male	4. RACE White	S. DATE OF BIRTH 10-26-1889	6. AGE (In years last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Talbot	Md.	
10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House in The Pines	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SCHOOL TEACHER & FURRIER	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY Talbot	13c. CITY OR TOWN OXFORD	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME Stephens L T + YI OR	First Middle Last	15. MOTHER'S MAIDEN NAME First Mary LILLIAN PORTERFIELD	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 214-34-7300	17. INFORMANT Mrs. MARY THORPE, WESTERLY, R.I.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 450X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. 465X (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediately					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Astroscum. Recent GI hemorrhage					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 10-25, 1968, to 12-7, 1968, that (I) (we) last saw the deceased alive on 12-5 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Stephen S. Conroy	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 12-7-68	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 12/19/1968	23c. NAME OF CEMETERY OR CREMATORIAL FORT LINCOLN	23d. LOCATION (City or Town) Washington, D.C.	(County)	(State)
24. FUNERAL DIRECTOR Maurice A. Neumann & Son	ADDRESS EAston, Md	25a. REC'D BY REGISTRAR DEC 10 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		



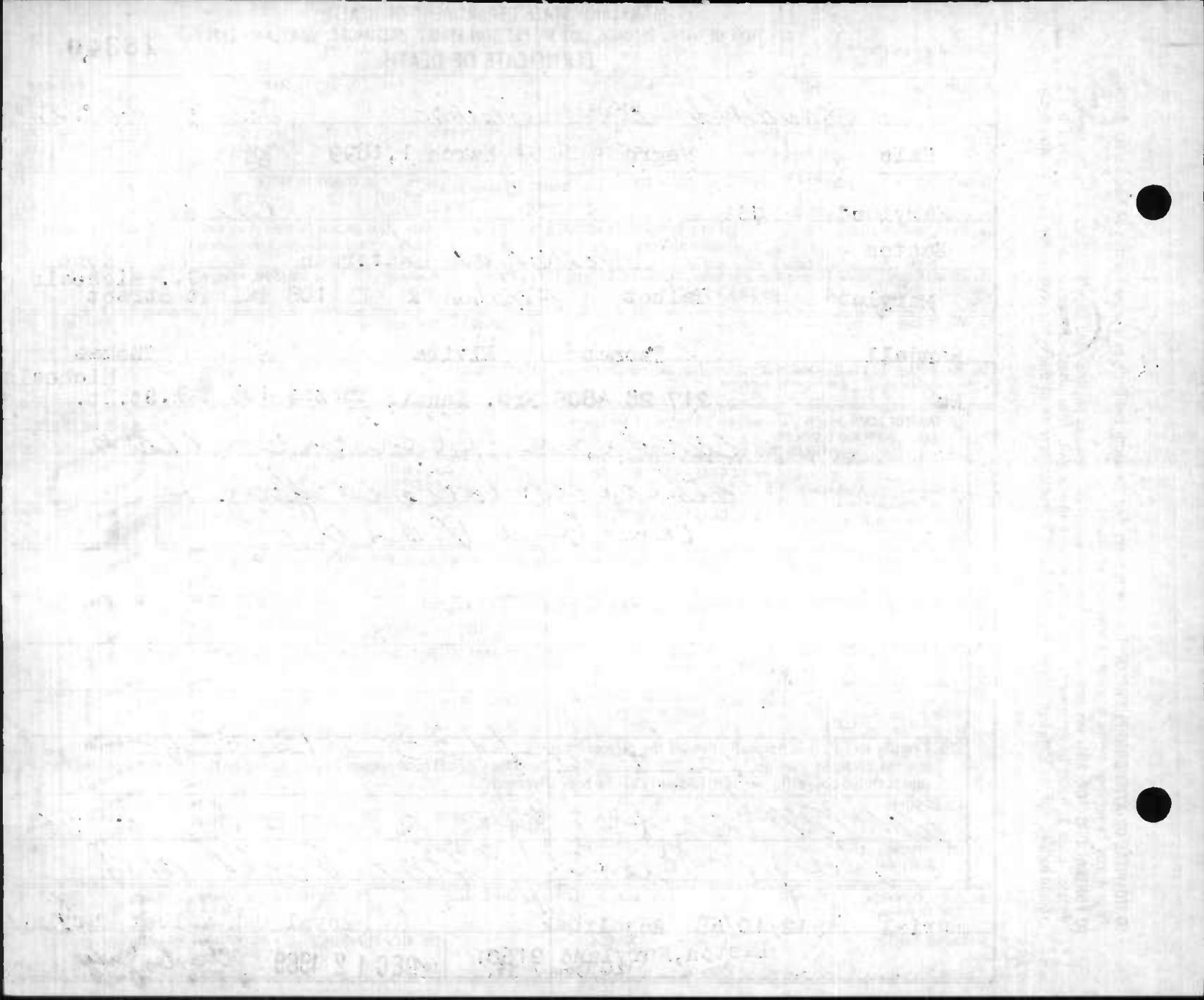
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

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**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

CERTIFICATE OF DEATH

1			18327			18340		
1. DECEASED NAME (Type or print)	First <i>Randall E</i>	Middle <i>Thomas</i>	Last	2a. DATE OF DEATH Month <i>Dec.</i> Day <i>8</i> Year <i>1968</i>	2b. HOUR <i>12:00 M</i>			
3. SEX Male	4. RACE Negro	S. DATE OF BIRTH March 1, 1899	6. AGE (In years lost birthday) 69	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Talbot</i>	Md.				
10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Waterman	12b. KIND OF BUSINESS OR INDUSTRY None					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Talbot	13c. CITY OR TOWN <i>Easton</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 108 Talbot Street	St. Micheals			
14. FATHER'S NAME First Randall	Middle Thomas	Last Elvira	15. MOTHER'S MAIDEN NAME First Thomas	Middle Elvira	Last Thomas			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. 217 28 4805	17. INFORMANT Mrs. Nannie Thomas	Address 108 Tal. St. St.					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>atherosclerotic cardiac & cerebro Vas d.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>cerebro Vas d.</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4221</i>								
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>at home, farm, street, factory, office building, etc.</i>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>1853</i> , to <i>12-8-68</i> , that (I) (we) last saw the deceased alive on <i>12-7-68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Henry M. Bresser Jr. M.D.</i>		22c. DATE SIGNED <i>12-8-68</i>						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/10/68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Royal Oak	23d. LOCATION (City or Town) Royal Oak Talbot Maryland	(County) Talbot	(State) Maryland		
24. FUNERAL DIRECTOR <i>Dashiell Funeral Home</i>		ADDRESS Easton, Maryland 21601	25a. REC'D BY REGISTRAR DEC 12 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

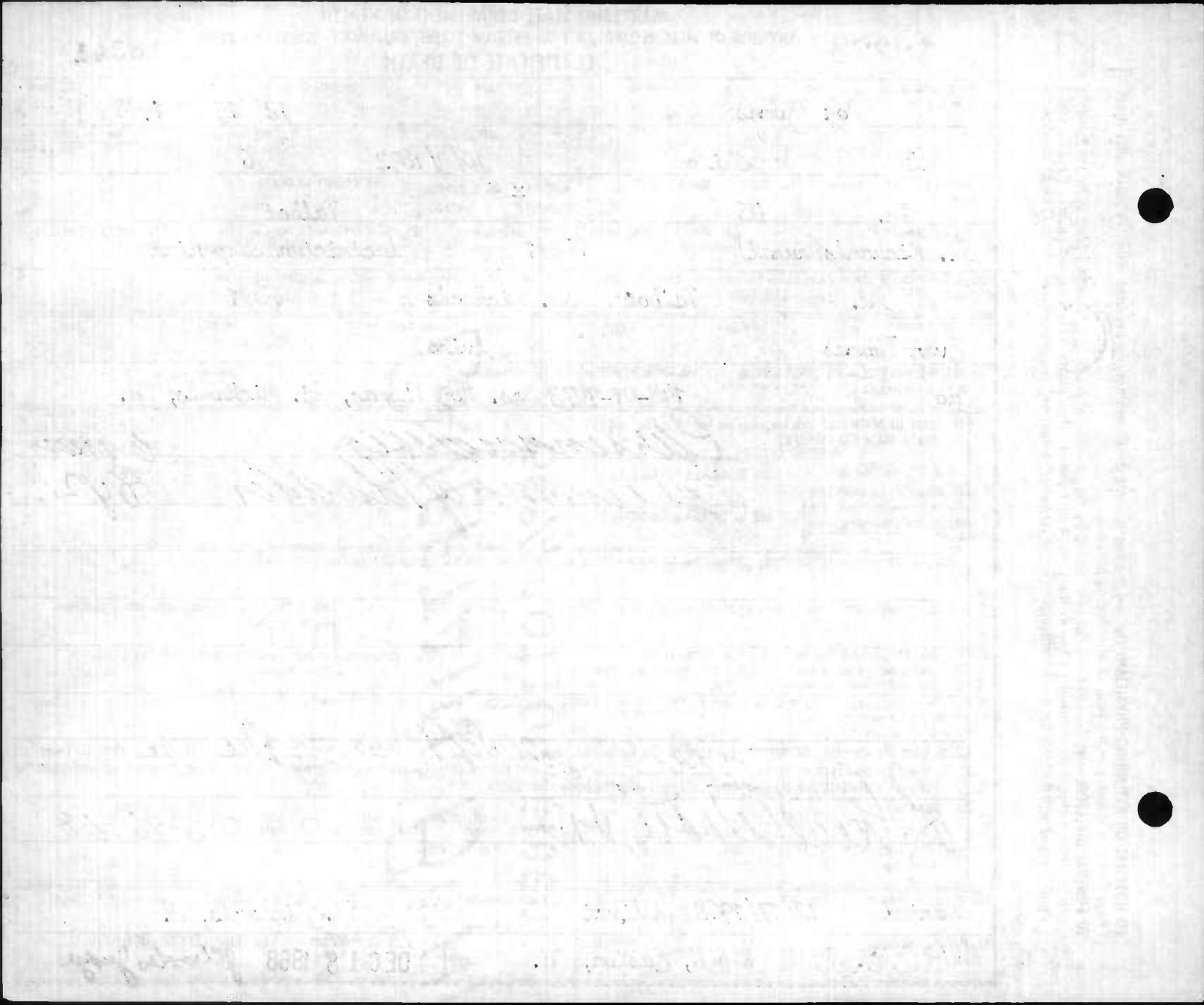
18328

18341

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>Roy Thomas</i>	Middle	Lost	2a. DATE OF DEATH Month Day Year <i>12 05 1968</i>	2b. HOUR M
3. SEX	4. RACE	S. DATE OF BIRTH <i>10/3/1892</i>	6. AGE (In years lost birthday) <i>76 yrs.</i>	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Pa.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>US</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <i>Talbot</i>			
10. CITY OR TOWN OF DEATH <i>St. Michaels (rural)</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>RFD#1</i>	12a. USUAL OCCUPATION (Kind of work done during last working day) <i>Cooking</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Caterer</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Talbot</i>	13c. CITY OR TOWN <i>St. Michaels</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>RFD#1</i>		
14. FATHER'S NAME	First <i>Evan Thomas</i>	Middle	Lost	15. MOTHER'S MAIDEN NAME	First <i>Elvira</i>	Middle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>148-01-9073</i>	17. INFORMANT <i>Mrs. Roy Thomas, St. Michaels, Md.</i>	Address <i>6 main</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>188X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Chronic nephritis</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8921</i>		
(b) <i>Chronic disease of Bladder</i>						
(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1810</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>At home</i>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>Office building</i>	21f. LOCATION Street or R.F.D. No. <i>220 Main</i>	City or Town <i>Baltimore</i>	County <i>Baltimore</i>	State <i>Md.</i>
22a. I certify that (I) (this hospital) attended the deceased from <i>10/17/68</i> , to <i>10/18/68</i> , that (I) (we) last saw the deceased alive on <i>13 Oct 68</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>R. Scull (Walt), MD</i>		DEGREE <i>MD</i>	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>12-16-68</i>
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
23a. BURIAL CREMATION, REMOVED (check)		23b. DATE <i>12/17/1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Olivet</i>	23d. LOCATION (City or Town) (County) (State) <i>St. Michaels, Md.</i>		
24. FUNERAL DIRECTOR <i>MURG E. NEUNAM & SON, Easton, Md.</i>		ADDRESS	25a. REC'D BY REGISTRAR DATE <i>DEC 18 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



18329

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#5, FilmG107 12/9/68 km

CERTIFICATE OF DEATH

18342

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH Month	3 Day	2b. HOUR Year
John James Toth				12	3	68 88 M
3. SEX	4. RACE	S. DATE OF BIRTH May 16 1919	6. AGE (In years last birthday) 49	2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
male	white	Dec. 3, 1968	YRS.			
7a. BIRTHPLACE (State or foreign country) Pa.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Talbot			
10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Albany Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) plummer and heating contr.	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Caroline	13c. CITY OR TOWN Federalsburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Long Branch Road		
14. FATHER'S NAME First John J. Toth Sr.	Middle	Lost	15. MOTHER'S MAIDEN NAME First Cecelia Dekan	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes	16b. SOCIAL SECURITY NO. W. W. II 194-10-7582	17. INFORMANT Mrs. Virginia L. Toth Federalsburg, Md.	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatostatic Cirrhosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (?) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1621 (b) <u>Cirrhosis of Liver</u> (?) DUE TO, OR AS A CONSEQUENCE OF (c) (?)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163X						
19a. DATE OF OPERATION 163X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) At home, farm, street, factory, office building, etc.			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>30 Oct</u> , 19 <u>68</u> , to <u>3 Dec</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3 Dec</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Burton Harrison MD		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 3 Dec 68	
22d. PHYSICIAN'S NAME (Type) BURTON HARRISON		22e. ADDRESS Carson Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE 12-10-1968	23c. NAME OF CEMETERY OR CREMATORIAL Great Cemetery	23d. LOCATION (City or Town) Federalsburg, Md.	(County)	(State)	
24. FUNERAL DIRECTOR Harrison Harrison - Federalsburg, Md.	ADDRESS	25a. RECEIVED BY REGISTRAR DEC 10 1968	25b. REGISTRAR'S SIGNATURE Judge			

SAC-1

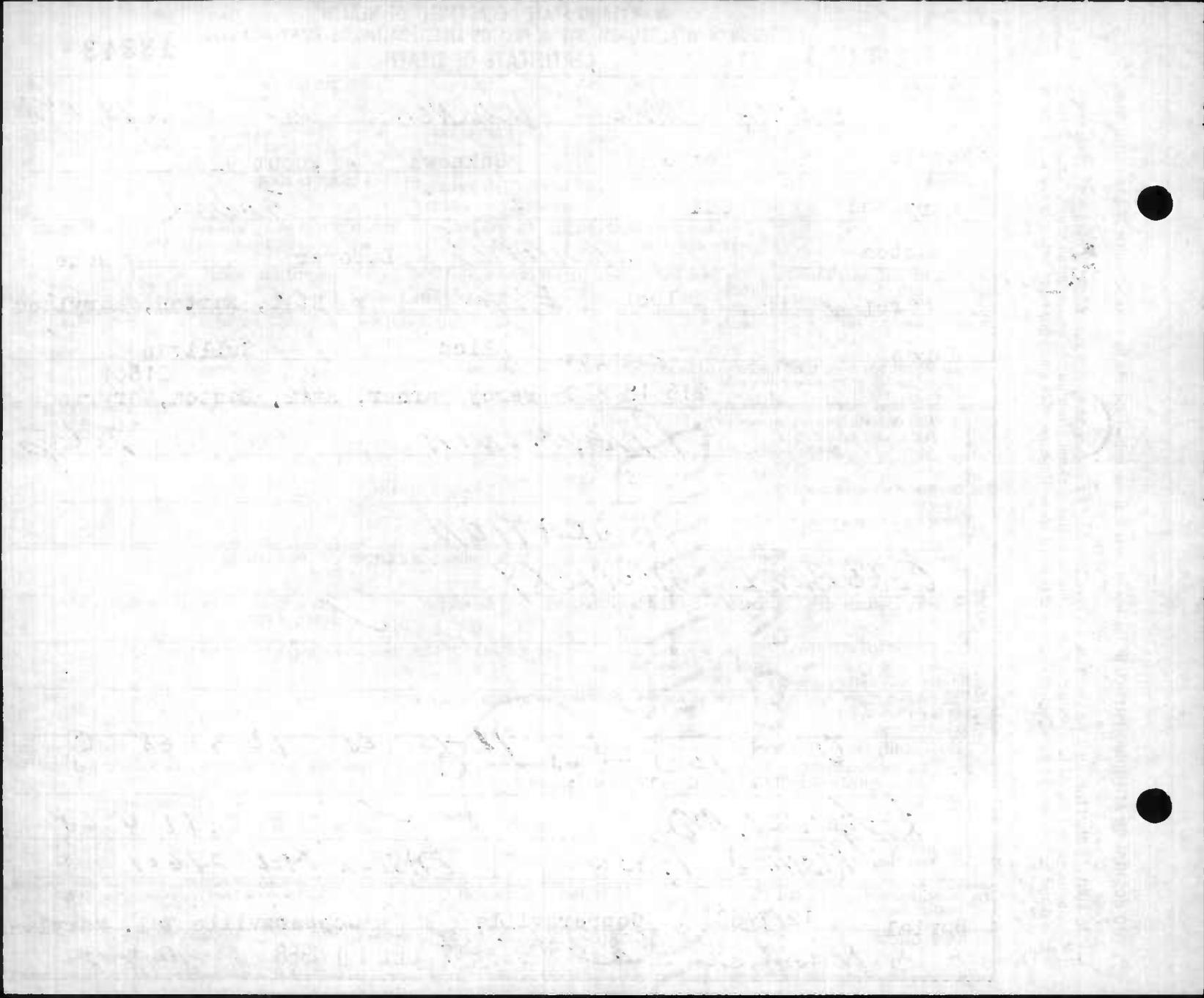
1000 SHORT

1 3 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH**

18330			18343				
1. DECEASED-NAME (Type or print)	First <i>Eliza Mae</i>	Middle <i>Worner</i>	Lost	2. DATE OF DEATH Month <i>Dec. 3</i>	2b. HOUR Year <i>1968 4:44 PM</i>		
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH Unknown	6. AGE (In years lost birthday) About 92 yrs.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Talbot</i>	Md.			
10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer	12b. KIND OF BUSINESS OR INDUSTRY None				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Talbot	13c. CITY OR TOWN <i>Easton</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt#2, Easton, Maryland			
14. FATHER'S NAME First James	Middle Roberts	15. MOTHER'S MAIDEN NAME First Alice	Sullivan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Years, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 216 18 8809	17. INFORMANT Percy Warner, Rt#2, Easton, Maryland	Address 21601				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 486X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 493X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) ASPIRATION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CEREBRAL APoplexy							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 12-3-1968 , to 12-3, 1968 , that <input type="checkbox"/> (we) last saw the deceased alive on 12-3-1968 , and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED 12-4-68	
22b. SIGNATURE <i>Richard Tyson, MD.</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.			
22d. PHYSICIAN'S NAME (Type) Richard Tyson		22e. ADDRESS EASTON MD 21601					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/7/68	23c. NAME OF CEMETERY OR CREMATORIAL Coppersville	23d. LOCATION (City or Town) Coppersville Tal.	(County) Maryland	(State)	
24. FUNERAL DIRECTOR <i>J.B. Nashill</i>		ADDRESS 926 1/2 St. Easton MD		25a. REC'D BY REGISTRAR DATE DEC 10 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

18331						18344	
1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR 3p M	
2. SEX	3. RACE	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) 84	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male	Negro		April 3, 1884	YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH				
Md	U.S.A.		Talbot				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY				
EASTON	Memorial Hospital	Labor					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER			
Md	Talbot	EASTON	NO	Route 4- Box 148			
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	
JOE		William		ROSIE	Wesley	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address				
No	218-30-1554	Cora	William EASTON Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA							
4270 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) UREMIA							
4341 DUE TO, OR AS A CONSEQUENCE OF							
(c) CONGESTIVE CARDIAC DISEASE							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
WEEKS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
GENERALIZED ARTERIOSCLEROSIS							
MEDICAL CERTIFICATION		19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While Not while at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from 11-23 - 1968, to 12-18 - 1968, that (1) (we) last saw the deceased alive on 12-18 - 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		Richard F. Tyson	DEGREE	ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type)		RICHARD F. TYSON	22e. ADDRESS	22c. DATE SIGNED			
			EASTON 21601 Md.	12-20-68			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 12/22/68	23c. NAME OF CEMETERY OR CREMATORIAL Richards	23d. LOCATION (City or Town) EASTON Talbot Md	(County)	(State)	
24. FUNERAL DIRECTOR		ADDRESS	25a. REC'D BY REGISTRAR DEC 27 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			

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1862

